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ABSTRACT

In introducing this annual report, the executive director of UNICEF delineates the four techniques for primary health care and basic services reported in the publication "State of the World's Children, 1982-1983." The ensuing review of UNICEF's activities illustrates highlights of the year's program cooperation, including trends and key events, by providing specific program profiles from different countries. In a discussion of child health and nutrition, the role of Zimbabwe's village health-work trainers is emphasized. Bangladesh, the Philippines, and Indonesia are highlighted in discussions of oral rehydration, immunization, breast-feeding, and children's growth. Other basic services for children described include clean water and sanitation in Mozambique, formal and nonformal education in India, urban basic services in Haiti, and women's activities in Indonesia. Childhood disabilities and appropriate technology are also briefly mentioned. Program support activities undertaken in Jamaica and Pakistan are described along with Lebanon's emergency relief and rehabilitation programs. Maps of UNICEF in action illustrate program commitments in the developing world, including governmental contributions. UNICEF's finances (income, commitments, and expenditures for the year) are depicted in a table and charts. An overview of UNICEF's philosophy, policies, methods of program cooperation, and supporting activities is also provided. (BJD)

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UNICEF

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1983

UNICEF Annual Report

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*Unable to serve full term of office.

Introduction

by the Executive Director, James P. Grant

In my introduction to the *Annual Report* last year, I wrote: "Not for a generation have expectations of world development and hopes for an end to life-denying mass poverty been at such a low ebb. Ironically, the determination to provide at least a 'safety net' to protect the most vulnerable of the world's children and their mothers is increasingly under challenge at the time that the means to accomplish this are relatively ready to hand."

My conviction that this irony cannot be passively accepted by UNICEF has been reinforced over the past year by our constant quest to revitalize that determination, and to challenge the malaise which permeates today's debates about world development prospects. Indeed, my optimism has had cause to grow, for when I made that statement I did not fully appreciate just how "ready to hand" are those means "to protect the most vulnerable of the world's children."

In late September 1982, a group of experts from several agencies involved in improving the lives of children gathered in a UNICEF conference room in our New York headquarters. For two days, we examined the findings of a year-long effort to analyze the "state of the art" of primary health care measures, specifically those intended to reduce the high infant and child mortality rates which characterize so many poor communities. During the course of that seminar we came to see that recent developments in social and biological sciences in several related fields present a new opportunity for bringing about a child health revolution which is low in cost and can be achieved in a relatively short span of years.

We realized that the "state of the art" is really quite advanced and that the key technical ingredients needed for a concerted campaign to reduce both child mortality and morbidity are even less costly than we had thought. A serious commitment to this "revolution" by governments and people could reduce disabilities and deaths among children in most developing countries (now exceeding 40,000 *each day*) by at least half before the end of this century—and in many countries, within a decade—as well as slowing population growth. We felt that this revolution could be—with the necessary commitment of political will and economic investment—as momentous for children in the decade ahead as was the Green Revolution for increasing grain production in many countries in Asia in the decade from the late 1960s.

Drawing in large part on the experience of earlier work supported by the World Health Organization, the United Nations Development Programme, the World Bank, other multilateral and bilateral assistance agencies, and non-governmental organizations, as well as UNICEF's own 36 years of field experience, our attention focused on four simple techniques which had become integral elements of the primary health care and basic services activities which UNICEF and others have been promoting for some time. These techniques in themselves cost very little: they are particularly suitable for tackling malnutrition-related infections and communicable diseases which take their heaviest toll among children; and they greatly increase the self-reliance capacities of low-income families.

The most important and dramatic of the low-cost techniques is the development of a simple oral rehydration home treatment for the world's largest killer of children: diarrhoea. This condition, often stemming from mild infection, ought to constitute no major threat to children's lives. But, in fact, five million children die annually from the dehydration it leads to, which mothers in poor families do not know how to treat. They have little or no access to professional medical services, so they simply watch helplessly while their child's life fades away in front of their eyes.

ICEF 9159/UNICEF

James P. Grant, Executive Director, who visited Lebanon in early July to witness needs at first hand, inspects damage at the Ras El Ain pumping station in the south.

Oral rehydration therapy, in the form of a simple solution of salt, sugar, and minerals dissolved in water, applied at home by the very same mother is a total remedy. It has been described as "potentially the most important medical advance of the century" by Britain's *Lancet*, one of the world's leading medical journals. A packet of Oral Rehydration Salts (ORS) costs less than US 10 cents to manufacture, and yet it remains virtually unknown in hundreds of millions of households where it is most needed.

ORS are not yet used or promoted in the majority of the world's hospitals and clinics, which still rely on expensive intravenous treatment requiring the use of medical facilities for severe dehydration. This kind of "last ditch" curative help is not available to the majority of families in poor communities. The lives of millions of children could be saved each year, and the health of many millions more improved significantly, if the use and availability of ORS was effectively promoted through health systems, mass media, educational channels, industry, labour and religious groups, with active support from national leaders.

The other techniques singled out in our seminar for special discussion because of their common attributes of being relatively low-cost in both financial and political terms were: universal child immunization; the promotion of breastfeeding; and the use of child growth charts kept by mothers in their own homes as a stimulus and guide to nutritional surveillance and proper feeding of the pre-school child. Special mention was also made of family spacing and food supplements which would also contribute significantly to improving children's health and reducing child mortality. But these measures are either more difficult (birth spacing) or entail considerable financial investments (food supplements).

None of these techniques is truly "new", although in many ways either the technology by which they are applied is recently enhanced, or our appreciation of their value is newly strengthened. What is new—and highly significant in terms of the potential use of these techniques for saving children's lives—is the increase in recent years in social organization and in the capacity to reach a far greater number of people. This is exemplified by the expansion of primary health care services, the widescale training of health auxiliaries, the growth in the number of women's groups, the increase in literacy, and the phenomenal spread of transistor radios and other communications media. This evolving network of social and administrative infrastructure reaching right down to the village level provides countries with dramatic new opportunities for spreading benefits among the poorest in their societies. It is the combination of the techniques with this capacity which we believe could, if the world wanted it, save a high proportion of the children's lives now being lost.

This was the message which UNICEF incorporated in its third, and most important, annual *State of the World's Children* Report: "New Hope in Dark Times," which was released in mid-December. I believe it provided the basis, at the start of the bleakest holiday season in a generation, for one of the most powerfully hopeful news stories of the decade. Certainly it has attracted more attention—from the media and from government policy makers, members of the international development community, scientists, and community leaders—than any other proposition put forth in any previous UNICEF publication.

As an example, the day that the Report was released to the press, I visited with British Prime Minister Margaret Thatcher in London. She called the Report "very exciting", and, recognizing that the measures it proposes are as valid for children in wealthy communities as those in poor, she asked to keep one of the growth charts—in Haitian Creole—which I had brought along as a sample. Indian Prime Minister Indira Gandhi, Swedish Prime Minister Olof Palme and French Prime Minister Pierre Mauroy similarly reacted with enthusiasm to the potential for child health breakthroughs described in the Report when it was presented to them.

Shortly before the Report's official release, I had the privilege of meeting with three assemblies of parliamentarians—in Africa, in Latin America and at the United Nations. In each case, our discussions of individual elements of these techniques prompted enthusiastic response, which I am confident will not be limited to the very strong endorsements which were contained in the reports of the two conferences, but which will be evidenced in the continuing efforts of these parliamentarians to guide their governments, and inform their constituencies, on the potential savings of lives and futures which each of the techniques represents.

For me, the tremendous world-wide enthusiasm with which *The State of the World's Children, 1982-1983* and its message were received was the high point of UNICEF's year, and a point from which we can all depart with renewed energy and faith in our mission for women and children in deprived communities. The essential story of the Report—a story which breaks the standard rule of journalism that "good news is not news"—is simply the day-to-day story of what UNICEF is all about. It is the story of our constant endeavour, in partnership with more than 110 governments throughout the developing world, to improve the quality of services for children, and increase their outreach to greater and greater numbers of those in need. In a more detailed—but no less exciting—way, it is the story also related in this ***Annual Report,*** in the review of UNICEF's achievements during 1982-83, and in the programme examples which bring alive the concrete ways in which UNICEF co-operation touches and improves human lives.

This story illustrates for me that unique capacity of UNICEF, which has always been considered the "people-to-people" arm of the United Nations: to reach and captivate the hearts of people with new appreciation of real opportunities to improve the lives of the world's poorest children and their families.

Given the innovative dedication of UNICEF's staff, the wise guidance of UNICEF's Executive Board, and the creative devotion of the National Committees for UNICEF and the many other governments, organizations and individuals with whom we have the privilege of working on behalf of children, I am confident that *each* year's work of UNICEF will represent "new hope in dark times".

James P. Grant

James P. Grant
Executive Director

UNICEF 1982-1983: a review

For UNICEF, 1982 was a year of sharpening of priorities as recession in the world economy deepened and the situation of children and women—the most vulnerable members of society—seriously deteriorated in many countries. World output grew during the year by only one per cent—significantly less than population growth—and unemployment was the worst in decades.

Children in many developing countries were adversely affected in three specific ways. Disposable family incomes fell sharply, especially among the poor. Government budgets for social services—including health, nutrition, education and water supply—were cut back. And flows of international development assistance stagnated as the industrialized countries fought economic recession with budget cuts.

In the developing world as a whole, per capita income fell by about 1.5 per cent in 1982. The fall was particularly abrupt in several Latin American countries which had previously experienced rapid growth. Only in the newly industrializing countries of southeast and east Asia was a certain level of growth maintained. It was in the poorest, and in certain cases war- or drought-ravaged countries of Africa south of the Sahara, dependent on the export of primary commodities, that the effects of continued world economic crisis were felt most severely.

The impact of these economic difficulties came through clearly in reports from UNICEF country offices. Many pointed out that poor households with declining incomes were the most severely affected by increased prices for foodstuffs and other essentials. To quote from one country report from Africa: "A 17 per cent increase in rice prices in May 1981 was followed by their doubling in May 1982 with substantial increases in the prices of other foodstuffs, petrol and other fuels. Previous surveys suggest that 'traditional' households suffer proportionately more than 'modern' households.

"... A shortage of foreign exchange limits drug and medicine imports, and the inadequate transport network hinders the distribution of the little that there is. Shortages of soap and basic foods make it hard to transmit messages of public and personal hygiene and nutrition convincingly. Lack of building materials limits school construction, and lack of paper the production of textbooks."

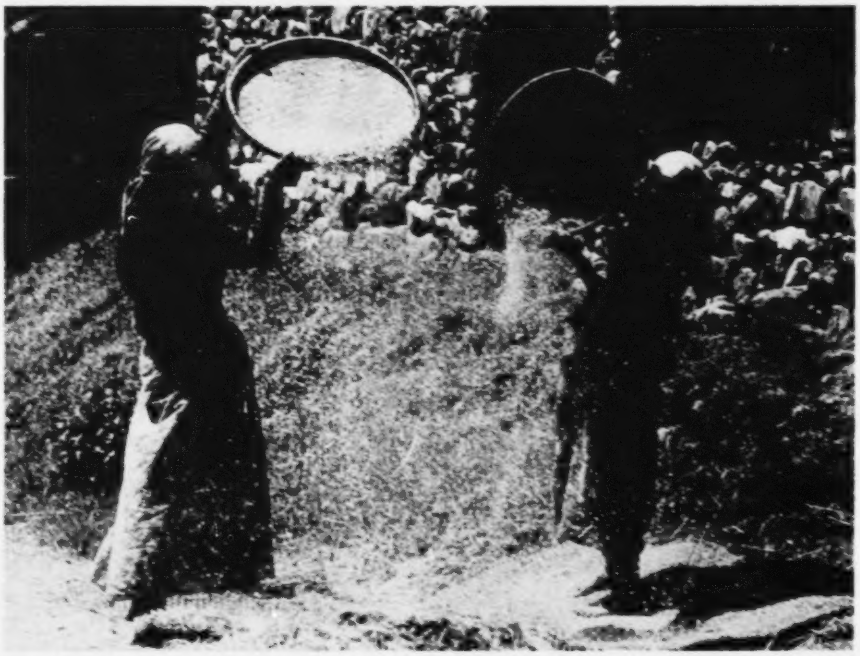
From Asia, another UNICEF field office reported: "The slashing of subsidies on petroleum products will mean an erosion of real income, which will affect particularly the needy and the underprivileged ... while the decision [to abandon the recently announced proposal to double the value of] food stamps will further aggravate the situation for those needy groups estimated at present to be about half the population. ...This will affect key areas of consumer spending, such as milk foods, drugs and pharmaceuticals, bread and flour, sugar and sugar products, and clothing. The impoverished social groups are trying to make do with much less as they strive to cope with the situation."

Encouragement could be found in the fact that some developing countries, despite their economic difficulties, were making determined efforts to reach low-income families. In several, the restrictions imposed by the world recession stimulated the search for innovative low-cost solutions. In one country in Latin America, for example, with a 100 per cent inflation rate and a multi-billion dollar foreign debt-servicing requirement, it was noted that, in real terms, total expenditures in the social sector would be bound to decline. However, the

ICEF 8757/Wolff

During 1982 the situation of women and children, the most vulnerable members of society, deteriorated in many countries as a result of the recession in the world economy.

government was levying a special turnover tax to finance cost-efficient measures to reach the lowest income groups and, in particular, their children. Pre-school services and the spread of simplified low-cost water and sanitation systems were some of the programmes to be emphasized. Similar efforts to reach the poorest families with low-cost measures, and to improve social planning, were reported from a number of developing countries, notably from southeast Asia and other Latin American countries.



ICEF 9109/Isaac

Globally, food production exceeded population growth in 1982. But progress was uneven; food deficit countries were increasingly dependent on a few grain surplus countries.

The critical needs of children and women in so many parts of the world at this time have reinforced the basic challenge to UNICEF: to review the role UNICEF can realistically play in alleviating those needs. Over the last year UNICEF has reviewed its priorities, its programmes and organization, in the effort to increase effectiveness and impact despite expectations that resources will grow very slowly or remain constant. Improvement of management at all levels of the organization has been a central concern throughout this process.

In the *State of the World's Children 1982-83* Report the Executive Director highlighted new possibilities in cost-effective measures in nutrition and primary health care, as outlined in his Introduction to this ***Annual Report***, and further detailed in the relevant sections of this Review. UNICEF already supports programmes in these specific areas in 60 countries and support to 15 more is planned.

Malnutrition remains one of the major concerns. Globally, food production exceeded population growth in 1982, and, with the exception of Africa south of the Sahara, increased harvests were recorded for all developing regions. But progress was uneven: inequalities of income and land distribution meant that food deficit countries were increasingly dependent on a few grain-surplus countries, and there were no signs of improvement in levels of malnutrition. As pointed out in last year's report, food emergencies have increased alarmingly in recent years, confronting the international community with a perennial problem. The parts of the world suffering from food emergencies are invariably those most difficult to reach, and those least well-served with the organizational infrastructures which make possible food aid distribution and therapeutic treatment for debilitated victims. It is the under-fives who are most at risk: medical evidence about the size and growth of the brain and the effect on young bodies of prolonged calorie-protein deficiency indicates that children who survive such deprivation are likely to suffer an inbuilt set of prohibitions on normal physical and mental development.

The chronically malnourished child is, however, only the extreme symptom of the overall hunger problem. The vast majority of children suffering from malnutrition are victims of persistent dietary deficiency which does not manifest itself in eye-catching pain and misery, but shows itself in listlessness, stunted growth, and the child's susceptibility to infections which take hold of already weakened bodies with remorseless effect. It is in providing the techniques for nutritional surveillance to identify such cases, promoting the treatment of respiratory and diarrhoeal infection through preventive health measures, as well as in nutrition education for mothers and the provision of food supplements that UNICEF, together with WHO and other partners, can most effectively co-operate with governments in their campaigns against malnutrition. The major initiative in this area is the WHO/UNICEF Joint Nutrition Programme, described later in this chapter.

Owing to the generous support of governments and private citizens around the world, UNICEF's resources for programme co-operation grew in 1982 despite the general stagnation in international development assistance. Expenditures on programmes and budgetary support came to $289 million, including $75 million in cash assistance, training costs and other local expenses, and $138 million in supply assistance.

The following sections of this review describe the progress which took place in the principal areas of UNICEF's co-operation. None of these should be regarded as complete in itself. The needs of children and of the communities in which they are born and brought up are so closely interrelated that genuine progress in one sector is impossible without progress in others. In certain cases the assignment of a given programme to one particular sector is arbitrarily decided according to the government ministry through which co-operation is extended. ☐

Child health and nutrition

Much of UNICEF's energy in 1982 was devoted to implementing cost-effective child health and nutrition measures, the traditional core of UNICEF's co-operation. Expenditures in these two closely connected areas came to $70 million.

Between the mid 1940s and the early 1970s there was a 50 per cent reduction in child death rates in many low-income countries. This progress has not been maintained. Malnutrition linked with diarrhoeal and respiratory diseases are the principal cause of continuing high infant mortality and child morbidity rates. These could be lowered substantially by the widespread application of comparatively low-cost measures.

It is gratifying, therefore, to be able to report significant advances in these critical areas of UNICEF activity, advances which may prove instrumental in achieving the goal of "Health for All by the Year 2000".

Among the encouraging features of the year was the successful start to the WHO/UNICEF Joint Nutrition Programme, which is providing inspiration for new UNICEF action on problems related to nutrition. Equally significant was the reinforcement of relationships with similarly motivated organizations within and without the UN system, which has led to the development of generally accepted strategies. In the world at large, there has been an upsurge of public awareness about the problem of hunger, particularly of the hungry and malnourished child. Severe food shortage in some of the least developed countries particularly those in Africa, has paraded this tragic stereotype of suffering before the public gaze. The impact in both industrialized and developing countries of the publication of the *State of the World's Children 1982-83* report was both evidence of, and a contribution to, this rekindled concern. The widespread media coverage given to the report has created a more solid and more widely acclaimed platform than ever before for UNICEF's advocacy on behalf of the young child.

This section of the Annual Report reviews last year's progress on nutrition, on primary health care, and on the specific low-cost measures which UNICEF sees as the main technical ingredients for a "child health revolution".

The attack on malnutrition

In 1982 the UNICEF Executive Board approved a five-year joint WHO/UNICEF Nutrition Support Programme in selected countries, initially funded by a special contribution of $85 million from the Italian Government.

It has been increasingly accepted in recent years that malnutrition is so much a part of the whole web of social problems that constitute poverty and the unhealthy and debilitating conditions which govern poor people's lives, that it cannot be tackled effectively in

ICEF 6494/Danois

Contrary to popular belief, malnutrition is not simply a problem of food shortage, but of poor nourishment combined with ill-health. A Thai mother prepares a meal.

Being available is what counts — ZIMBABWE

Once a week the women of Bushu village meet in their club, carrying their small children on their backs in a towel or shawl. Their song fills the air: "*Madzimai ngatishingei kusumudzira Zimbabwe*..."—"Women be strong to rebuild Zimbabwe."

Nine months ago these women were among the hundreds of people in Bushu who gathered to select two people as village health worker trainees. Mrs. Ebbermore Marange, a big, cheerful, capable woman was one of the two. She went away for her UNICEF-assisted training course, and has now been back at work for six months.

Mrs. Marange was able to add her new knowledge to her life's experience, which includes bearing and raising her own ten children. But she knows the children of these women at the club almost as well, for she herself is one of them.

Today Mrs. Marange talks about weaning foods, prepared from vegetables grown locally. The benefits of breastfeeding and the dangers of the feeding bottle are already well-known from earlier meetings. Mrs. Marange has a poster showing different vegetables, and asks the women which ones they use for weaning. Discussion reveals that not all the women have yet planted vegetable gardens, but most are keen.

Those who already have their plots established describe how to go about it. It is important to fence the gardens to keep out the animals, as Mrs. Marange emphasizes. The women in another village not far away wanted to grow vegetables together, but had no fenced-in place to do so. An idea occurred to them: why not make good use of the security fence which had been put up to make the "keep"—or protected village—during the war of independence? They applied to the District Administrator and he gave them permission. "Now," says Mrs. Marange, "the fence keeps the cattle out, instead of keeping the people in!"

The women laugh at Mrs. Marange's story. They listen to her attentively, and enjoy learning from her. Respect and likeability are important keys to Mrs. Marange's success. Some of the women invite her to come and visit them. They want advice about starting a garden, or about the health of someone in the family.

Diarrhoea is still common, although decreasing. One of Mrs. Marange's earliest talks was on public health. She encouraged the women to dig a communal refuse pit and make compost heaps. Now almost all the women have refuse pits at home. Some have moved the cattle ***kraals*** further away, and their family living quarters are less troubled by flies.

Home visits take up a lot of Mrs. Marange's time. But she makes the time—once she's finished her early morning household chores, her work in the family's fields, and seen her younger children off to school—because she thinks it's important. And it won't take so long once she has her UNICEF bicycle.

What does she think is the most important attribute for a health worker like herself? Her reply is immediate: "Being available to people. That's what counts above everything else." How long will Mrs. Marange go on being "available" in her new job? She gives a big laugh. "Why, for as long as they want me."

ICEF 9311/Gezelius

isolation. Contrary to popular belief, malnutrition is not simply a problem of absolute food shortage, but a problem of poor nourishment combined with ill-health. The WHO/UNICEF programme is accordingly designed to support a range of activities, mostly within the broad context of expanded primary health care services. Some activities are directly related to nutrition, while others are intended to create a framework within which better nutrition becomes a practical reality for those with children most in need.

Better weaning and child feeding practices are to be emphasized, as is the importance of breastfeeding in the first months of life. The treatment of diarrhoeal disease by oral rehydration and the extension of immunization programmes are also stressed. Among the activities less obviously associated with health and nutrition is support for community-based day-care for young children. Support will also be given to the spread of more appropriate household technology designed to reduce women's domestic burden and to improve family food production and conservation. Governments will also be encouraged to establish mechanisms whereby very low-income families will have access to food supplements at concessional rates.

The first countries to be included in the new WHO/UNICEF programme are Sudan, Tanzania, Mali, and Haiti. In Haiti a beginning has been made with one aspect of the programme, a national campaign in which many non-governmental organizations are involved, to promote the treatment of diarrhoeal disease with oral rehydration salts. In each of the other three countries, one geographical area has been selected for the organization of convergent services from several sectors, including health, education and agriculture.

Preparations for programme development are also proceeding in Angola, Burma, Ethiopia, Mozambique, Nepal, Nicaragua, Indonesia, Pakistan, Peru, Somalia, in the Andean countries, and in some countries served by the Caribbean Food and Nutrition Institute. (A profile on nutrition education activities supported by the CFNI appears on page 30.) In all these countries, initiatives are underway to co-ordinate with the specialized activities of other agencies in the UN system, so as to ensure a multisectoral approach towards nutrition, health, and food security.

A good midday meal for a child in pre-school is provided with UNICEF support.

ICEF 9310/Gubb

CHILD NUTRITION: In 1982 UNICEF

- co-operated in nutrition programmes in 90 countries: 41 in Africa, 21 in the Americas, 22 in Asia, and 6 in the Middle East region
- helped to expand applied nutrition programmes in 94,600 villages, equipping nutrition centres and demonstration areas, community and school orchards and gardens, fish and poultry hatcheries
- provided stipends to train 36,100 village-level nutrition workers
- delivered some 24,438 metric tons of donated foods (including wheat flour, non-fat dry milk, special weaning foods and nutrition supplements) for distribution through nutrition and emergency feeding programmes

While the new WHO/UNICEF programme was getting underway, UNICEF's ongoing activities in nutrition accelerated in 1982, with substantially increased levels of expenditure. Many programmes benefited from closer relations between UNICEF and other UN bilateral and voluntary organizations, as well as academic and research institutes.

There was continued support for grassroots activities to improve household food production, including vegetables and dairy products suitable for weaning, in countries such as Burma, Dominican Republic, Somalia and Thailand. Food and nutrition surveys were supported in a number of countries, including Afghanistan, China, Egypt, and Laos. Training and education in nutrition for mothers and for community workers continued to be a prominent feature of many health and nutrition-related programmes (see the Zimbabwe profile opposite).

UNICEF also expanded its support to nutritional monitoring and surveillance in Angola, Botswana, Nepal, Sao-Tome and Principe, and Uganda to enable early action to be mobilized against the risk of widespread under- or malnutrition. Co-operation in campaigns against specific nutrition-related diseases, such as goitre and vitamin-A deficiency, was maintained in several countries, notably Burma, Bangladesh, India and Pakistan. (A profile on the salt iodination programme to combat goitre in Pakistan appears on page 31.)

There were a number of examples of promising integrated approaches to nutritional problems. In Nepal, for example, a joint attack on poverty, disease and food shortage is being mounted through a programme that includes an easy credit scheme for small farmers and landless village families. India's Integrated Child Development Services, a programme launched on an experimental basis in 1975, is poised for a dramatic expansion. (See profile on page 21.) In Indonesia, the national programme for improving child nutrition, known by its Indonesian acronym UPGK and supported by UNICEF, has popularized among mothers the idea of monitoring their children's growth (see page 16.) ☐

Primary health care

ICEF 9152/Sprague

The primary health care approach continues to be widely advocated by UNICEF. In the outskirts of Dakar, Senegal, a regular child-weighing session is held under a tree.

Since 1975, working with WHO, UNICEF has promoted Primary Health Care (PHC) services in the developing countries as a means of extending the health service coverage nationwide. In 1978 an international conference at Alma Ata, USSR, endorsed the goal of "Health for All by the Year 2000", through the application of the Primary Health Care strategy. PHC uses health workers chosen by the community for curative, preventive and promotional tasks. If these health workers are properly trained, supported, and supervised, they are able to diagnose and treat four-fifths of children's ailments.

More countries were moving towards the PHC approach in 1982, but progress overall has been uneven. Many UNICEF field offices reported that the PHC philosophy, which depends on community organization, is still not well understood at influential levels in certain countries. Consequently, UNICEF offices gave considerable attention to PHC advocacy at national level, with the aim of promoting the political support for PHC which is an essential prerequisite for its adoption.

In Sri Lanka, a major effort was made to reach parliamentarians with arguments in its support. From Nepal, the UNICEF country report stated: "the development of local political awareness will definitely have more of an impact on the development of PHC and real community participation than any other factor."

Belize is one of the countries where there was encouraging support for PHC: a policy statement was issued adopting PHC during 1982. Several others—Guatemala, Malawi, and Syria, for example—requested UNICEF co-operation in planning additional PHC programmes. Yet others, such as Cameroon, planned to expand their PHC programme from an experimental pilot project to national dimensions.

In countries where the widespread training of community health workers (CHWs) has taken place, problems of providing them with adequate support and supervision have been widely encountered. Too few resources are available to support services at community level, which requires reallocation from urban hospitals towards PHC for underserved populations in the rural areas. Those supervising the community-based health workers are often too few, or are not oriented towards the PHC approach. Transport is often inadequate for reaching remote communities, and there are many problems associated with logistics and supply. UNICEF is therefore seeking ways of extending co-operation to help refashion health service infrastructures so as to make the CHWs fully effective in their communities.

The third problem identified by UNICEF field offices is the failure to involve communities sufficiently in decision-making and in programme management. This results in poor utilization and low coverage, which is especially apparent in some immunization programmes. Community involvement is being fostered by an increased emphasis on communication and education programmes: in connection with immunization, these have been undertaken in Bangladesh, Jamaica and the Philippines. In Lesotho, a special infrastructure has been set up in clear recognition of the priority to be given to community involvement in health.

Another problem concerns the integration of services, both within the health sector (child immunization, for example, should not be detached from MCH); and between the health sector and other related sectors such as water supply and sanitation. Integrated area approaches, such as those now underway in India, Oman, and Pakistan, have helped to focus on intrasectoral liaison and joint planning. In Costa Rica, Cameroon, and in a major water supply programme in Nigeria's Imo State, intersectoral collaboration has been achieved by providing special training sessions for government officials from a number of sectors operating at local or regional levels.

A need has also been identified for information and monitoring systems within the health services. The importance of regular evaluation and, if necessary, re-programming of PHC has been accepted by several governments. Important new initiatives such as the reorientation and restructuring of health services, and in the redefinition of the role and functions of health workers, have resulted from UNICEF-assisted evaluations in countries such as Angola, Lesotho, and Tanzania.

Finally, it seems that in certain countries, mothers' and children's health are still not receiving priority within PHC services. Clearer targeting on the mother and child is needed if a major impact on childhood mortality and morbidity is to be realized.

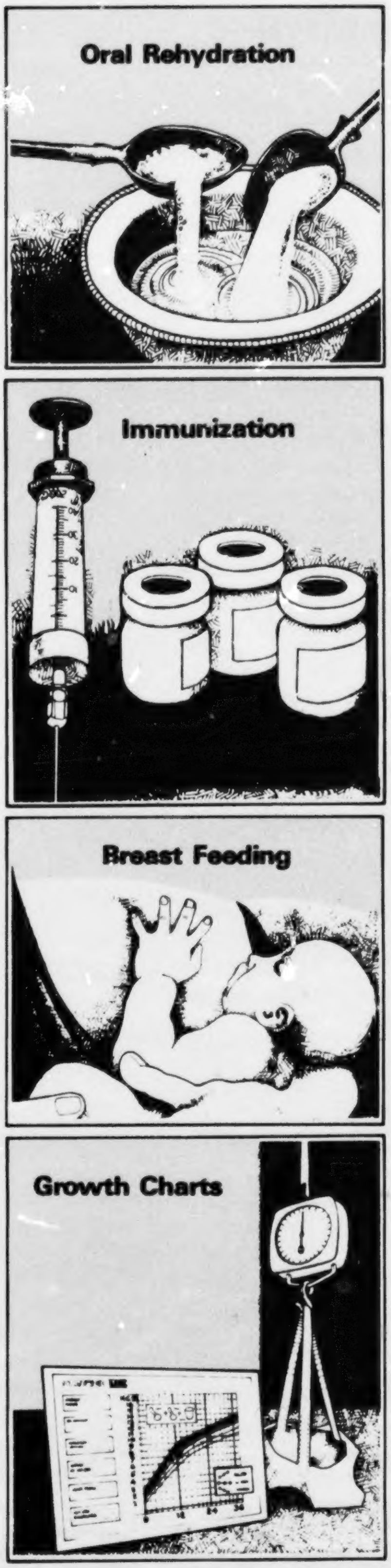
Towards a child health revolution

It therefore seemed timely towards the end of 1982 for UNICEF to highlight certain scientific and technical "breakthroughs" that offer opportunities for cost-effective child health benefits within the context of PHC. In his *State of the World's Children 1982-83* report, the Executive Director cited four such opportunities, which, if fully utilized, might bring about a "child health revolution". (See the Introduction to this report by the Executive Director on page 3.) These are: oral rehydration for the treatment of diarrhoea; universal child immunization; the promotion of breastfeeding and sound infant feeding practices; and the use of growth charts for the nutritional surveillance of the young child.

A meeting of the WHO/UNICEF Joint Committee on Health Policy in February 1983, which reviewed progress in PHC implementation and towards reaching the goal of Health for All, endorsed the actions for mothers and children proposed in the *State of the World's Children* report. It was clear that these actions should be undertaken as part of the strategies which strengthen the development of the PHC infrastructure.

CHILD HEALTH:
In 1982 UNICEF

- co-operated in child health programmes in 107 countries: 46 in Africa, 23 in the Americas, 30 in Asia and 8 in the Middle East region
- provided grants for training, orientation and refresher courses for 69,000 health workers: doctors, nurses, public health workers, medical assistants, midwives and traditional birth attendants
- provided technical supplies and equipment for 44,800 health centres of various kinds—especially rural health centres and subcentres
- supplied medicines and vaccines against tuberculosis, diphtheria, tetanus, typhoid, measles, polio and other diseases



The four elements which, if widely applied within the PHC context, could bring about a "child health revolution".

Oral rehydration therapy

Diarrhoea is the greatest single cause of death among the developing world's children, accounting for an estimated five million deaths a year. The average child in a poor community in the developing world will have six to sixteen bouts of diarrhoea a year, each of which can increase malnutrition and interrupt growth.

Prevention of diarrhoea has long been a WHO/UNICEF priority, and prevention is largely a matter of clean water, better sanitation and health education—programmes which UNICEF widely supports, but whose results are not quickly realized. Oral rehydration therapy (ORT) offers a simple, low-cost method of treatment. Diarrhoea kills through dehydration. Until a few years ago the only treatment for severe dehydration was intravenous maintenance of the fluid balance: saline solutions taken orally are poorly absorbed during a bout of diarrhoea. Treatment was revolutionized by the discovery that adding glucose to a solution of salt and water allows the body's rate of absorption to increase by 2,500 per cent. The ingredients should be correctly balanced, but the "recipe" is simple to follow.

Some 49 countries have now embarked on national diarrhoeal disease control programmes. In 1982 UNICEF supplied 25 million sachets of oral rehydration salts and supported local production of another 20 million sachets. Some countries are importing in bulk through UNICEF and doing their own packaging.

Equally important are remedies using boiled water and a little salt and sugar, and instruction to mothers on how to prepare the recipe for the treatment of their children. In this context, communications campaigns about ORT—sachets and home remedies—are vital. Cameroon, Indonesia and Peru are examples of countries where intensive efforts are being made to

A little salt, a little sugar

"Why should this baby die of diarrhoea?" asked 45-year-old Mrs. Anarun Begum, a village health worker. In her arms she gently held a two-year-old boy and was patiently feeding him liquid with a spoon. The boy had been suffering from serious diarrhoea since the previous day and was getting weaker. His mother had brought him to Mrs. Begum because she knew there was a way to save her baby by oral rehydration therapy, using a mixture of salt, sugar, sodium bi-carbonate and potassium chloride. ORS—Oral Rehydration Salts—comes in a small plastic packet, which needs to be diluted in one *seer* (roughly one litre) of tubewell water and administered to the diarrhoea patient.

In Bangladesh, thousands of small children fall victim to diarrhoea. For young children, especially in the rural areas, even a loss of 15 per cent of body fluids can cause dehydration and eventually lead to death. The National Oral Rehydration Programme was started in 1979 to train village health workers to use ORS and prevent diarrhoea being a deadly killer among young children.

"I lost my first son to diarrhoea. That's why I wanted to participate in the ORS training programme," said Mrs. Begum. She lives in an area called Tongi, a newly industrialized section just north of Dhaka city. Behind the modern factory buildings on the trunk road, there are still villages with people following their traditional agricultural way of life. Mrs. Begum's day-long training took place in the Social Welfare Centre and was conducted by the local Health Inspector.

Besides demonstrating how to use the ORS packet, the training emphasizes that workers must overcome cultural myths. A Bangladeshi mother tends to stop feeding, even breastmilk, whenever she finds that her child has a running stomach, which makes the child's condition worse. The trainees are taught to encourage mothers to continue feeding children with loose bowels.

With assistance from UNICEF, ORS production centres were set up in four districts: Dhaka, Comilla, Jessore and Rangpur. The centres can now produce 2.5 million packets annually. Each packet costs *taka* 1.20 (US 5 cents) but is distributed free to health workers and health complexes. After a day's training, each health worker receives ten packets of ORS mixture to take home. Every time the health worker administers a packet to a patient, he or she records it in a report book, and more packets are supplied regularly by family welfare workers. By 1982, over 98,000 Village Health Workers had been trained.

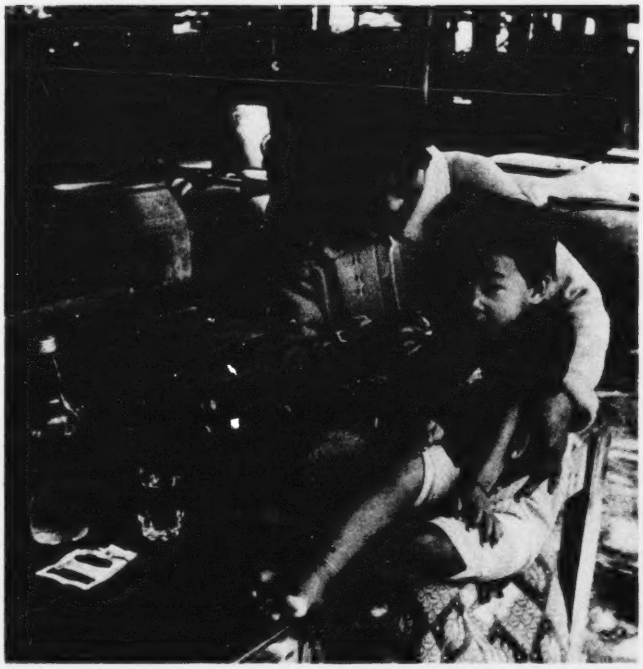
Although ORS production is increasing, the production level is still not high enough to meet the national demand. It is believed that at least 20 million packets would have to be produced annually. Due to the logistics problems which are frequent in remote areas, the home-made solution called *lobon-gur* is also well recognized. This approach has been promoted by the Bangladesh Rural Advancement Committee (BRAC) since July 1980. Nearly 900 BRAC field workers in five pilot districts are knocking at people's doors to teach them how to make *lobon-gur.*

Using flip charts, workers stress the seven points to remember in a case of diarrhoea. A pinch of salt and a fistful of molasses in half a *seer* of water is the recipe that can save a child. "Village mothers easily learn to make *lobon-gur.* However, the difficulty lies in persuading them to believe that such a simple thing can save a child from dehydration," said Dr. Rahman, project manager of the Oral Therapy Extension Programme at BRAC. More than 530,000 households were visited between July and December 1982, and Dr. Rahman believes that at least one-third of the mothers actually used *lobon-gur* in cases of diarrhoea.

Whatever the approach may be, this solution is within the reach of villagers. "It really works," said Mrs. Begum, "but if the condition is very serious, I am told to refer to the health clinics." A little salt, and a little sugar: a simple solution to save children from diarrhoea, the deadly killer.

ICEF 9288/Khan

promote ORT through information campaigns with support from UNICEF. In-service training in ORT for all levels of health workers, including those in the community, is being assisted. Some of the results have been dramatic. In Narangwal, India, the death rate among young children has been halved by the use of ORT and penicillin. In Nicaragua, UNICEF helped train 1,400 people to teach mothers the use of oral rehydration salts. A profile of UNICEF's co-operation in a major ORT programme in Bangladesh appears opposite.



ICEF 9308/Nikomrat

After instruction at a health centre in Thailand, a mother gives her child a dose of oral rehydration salts prepared with boiled water.

Immunization

Measles, diphtheria, tetanus, whooping cough, poliomyelitis and tuberculosis kill an estimated five million children a year in the developing world, and contribute significantly to the incidence and severity of childhood disabilities. WHO has long urged that all children should be immunized against these six diseases. Recent scientific advances have made vaccines more reliable and less dependent on constant refrigeration up to the moment of use. Costs have also declined: measles vaccines now cost less than 10 cents per dose. It has also been demonstrated that para-professionals can administer all these immunizations effectively.

UNICEF has been associated with WHO's Expanded Programme of Immunization (EPI) for a number of years and is the main supplier of vaccines to about 80 countries in Asia, Africa and the Middle East. UNICEF also provides "cold chain" equipment—refrigerators, cold boxes, transport—to enable vaccines to be kept active up to the moment of use. In China and Vietnam, UNICEF is helping establish vaccine production plants.

There is still a long way to go before universal child immunization is achieved. UNICEF participated in national EPI evaluations in eight countries in 1981 and 1982. The most effective programme evaluated is in Lesotho, where about 40 per cent of the children have been immunized. In many countries, because of logistics and management problems, immunization does not extend much beyond urban areas. When immunization services are provided through an administrative structure of their own, as is often the case, coverage is limited. Most countries also report poor attendance for follow-up doses.

UNICEF has been helping countries tackle organizational problems by support to workshops for senior and middle-level managers and for field workers. By the end of 1981, more than 4,500 national and international personnel had participated in intensive EPI-related courses. A number of countries, including Angola and Swaziland, are now attempting to integrate EPI organizationally into their Maternal and Child Health (MCH) services. Several countries are undertaking mass mobilization drives in support of child vaccination, examples being the Philippines, Jamaica and Bangladesh. UNICEF is supporting several of these campaigns.

ICEF 6746/Liftin

While her older brother—whose turn is next—looks on anxiously, a little girl receives a BCG injection against tuberculosis in a clinic in Istanbul.

Breastfeeding

The advantages of breastfeeding are associated with improved nutrition and hygiene. Bottle-feeding is especially hazardous in poor communities where it is impossible for mothers to follow the procedures of sterilization and correct dilution that bottle-feeding demands. In recent years the immunological properties of breastmilk have been more widely appreciated. Even in a hospital setting, breastfed babies have far fewer infections than bottle-fed babies. Moreover, breastfeeding serves in many cases as a natural contraceptive, increasing the intervals between births.

The decline in breastfeeding in many developing countries, most marked in higher income countries such as Brazil, Chile, and Singapore, has caused considerable alarm. The commercial promotion of artificial breastmilk substitutes is one cause for concern. In 1981 the World Health Assembly adopted an International Code of Marketing of Breastmilk Substitutes, recommending the elimination of direct consumer advertising and of all promotion of formula feeds in health facilities. While only a few countries had formally adopted the Code by end 1982, 12 had banned the advertising of breastmilk substitutes and more than 20 were developing national regulatory measures.

The campaign to halt and reverse the decline of breastfeeding in the developing world is receiving UNICEF's fullest moral and material support. Twenty-four countries with which UNICEF co-operates reported activities for the promotion of breastfeeding in 1982. Brazil's comprehensive campaign to support breastfeeding has expanded vigorously, to include studies, training of health personnel, measures to enable working mothers to breastfeed, hospital rooming-in for mother and infant, and pressure on food companies to abide by the Code.

Information, education and training activities in support of breastfeeding were reported from 16 countries. These included the production of handbooks, slides and films for health workers, and media campaigns using radio, TV, newspapers, magazines and posters. In the Arab world, in co-operation with governments and media, the benefits of breastfeeding were pro-

Tearing down the infant formula posters

As more and more babies in the developing countries are delivered in hospitals, hospital practices which encourage or discourage breastfeeding become a critical issue.

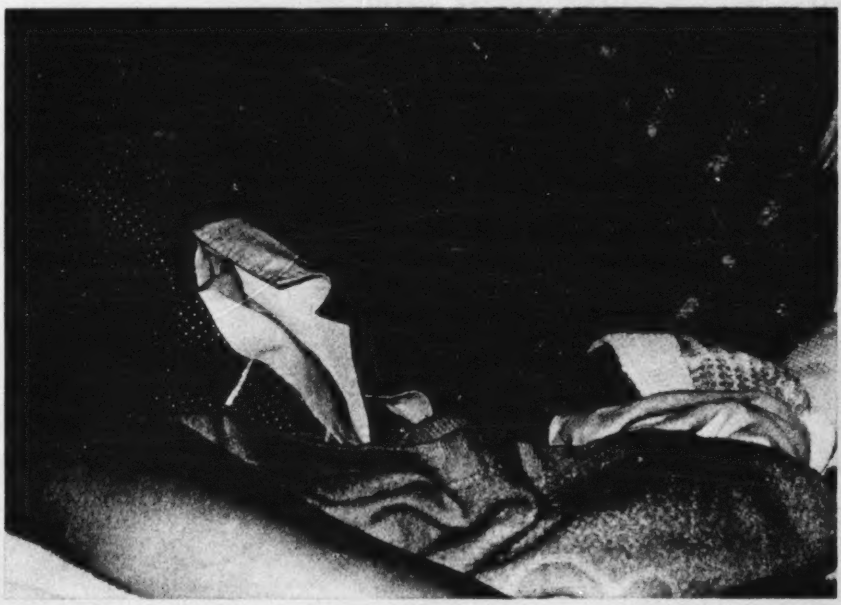
In Baguio General Hospital in the Philippines, thanks to a campaign launched a few years ago by the Chief of Pediatrics, Dr. Natividad Relucio-Clavano, no infant formula at all is used. All babies are fed on breastmilk, and the results in health terms have been dramatic.

Prior to 1975, Dr. Clavano recalls, the maternity unit at Baguio General was run along lines long-established in the Western teaching hospitals where she and her colleagues were trained. Babies were separated from their mothers at birth, they were routinely given supplementary feeds, formula company advertisements festooned the walls of the nursery. The idea of isolating the new-born babies was to protect them from infection, but it didn't work. Diarrhoea and other ailments were common in the nursery, and fewer and fewer mothers were breastfeeding when they left the hospital with their babies.

In 1975 Dr. Clavano went to London to work with Professor David Morley of the University of London's Tropical Child Health Unit. "My training with Dr. Morley was a turning point in my life," she recalls. It had long been recognized that from a nutritional and psychological point of view "breast is best". Now researchers were homing in on a host of anti-infective and immunological factors in breastmilk. It was increasingly evident that breastmilk gives active protection against many of the diseases artifically-fed infants were prone to contract.

Dr. Clavano returned to the Philippines determined to launch her own campaign for breastfeeding, starting in her own hospital. She tore down the formula companies' posters in the nursery and, with the co-operation of the Chief of Obstetrics, Dr. Keithley Santos, began to change the maternity unit's procedures so as to encourage breastfeeding in every way.

Nursing began while the mother and child were still in the delivery room. Except for the very sick, all the babies "roomed-in" with their mothers. Regular workshops and



ICEF 9312/Maglipon

PHILLIPINES

discussion groups were held to re-orient the nursing staff. Eventually, all artificial feeds were dispensed with. If a mother was too ill to nurse, another mother would volunteer as a wet-nurse. A breastmilk bank was set up in the nursery so that premature infants who were too young to suckle could be fed breastmilk by eyedropper.

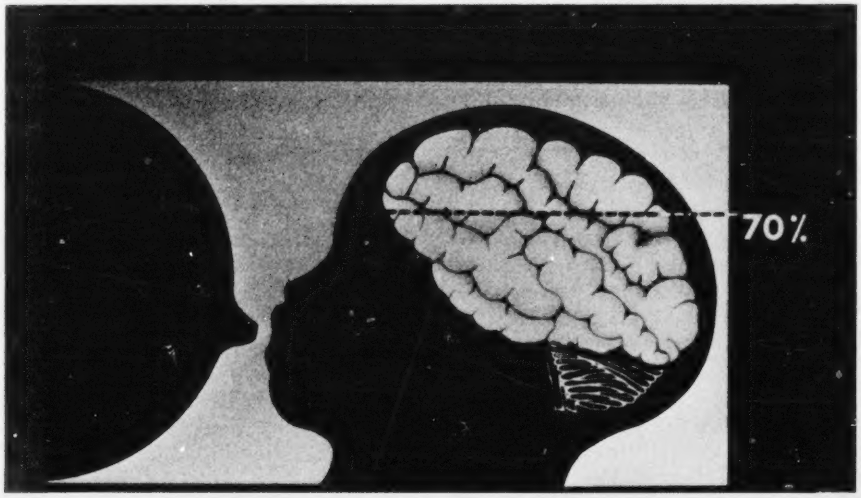
Baguio General Hospital caters to people of all economic classes, and many of the mothers come from the slums and are very poor. For them in particular, establishing successful lactation right after delivery is very important. In hospital surroundings, bottle-feeding may not be risky, but once the mothers return home the living environment and lack of sanitation—not to mention the over-dilution of formula that poverty may force upon them—can make bottle-feeding a baby killer.

In the two years that followed the quiet revolution in the maternity unit, the mortality rate among new-born babies dropped by 95 per cent, and diarrhoea almost disappeared. Any doubts the staff might have harboured about the value of the new routines completely vanished.

Baguio's pioneering experiments in transforming their maternity practices are now recognized widely throughout the Philippines, and internationally. The hospital has become what UNICEF calls the model for other health institutions to follow, and the site for training and reorientation of medical staff from all over the country.

During the next UNICEF country programme, from 1983 to 1987, a concerted effort under the co-ordination of the Ministry of Health will be made to promote breastfeeding countrywide. The experience of Baguio has paved the way for the promotional activities which are now about to get underway. It took time and effort to change the maternity routines at Baguio, but as Dr. Clavano asks, can anyone doubt that it was worth it?

This graphic, illustrating the effect of poor nutrition on the growth of the infant's brain, comes from a slide-set produced by UNICEF for Brazil's breastfeeding campaign.



ICEF 9313/UNICEF

moted to health and nutrition workers and to the general public. In Zimbabwe, booklets on the advantages of breastfeeding and the need to control the promotion of infant formulas were sent to 25,000 health workers.

Since the strong comeback for breastfeeding in North America and western Europe, artificial feeding can no longer be regarded as the inevitable concomitant of progress. Fortunately, in many countries breastfeeding is still practised by the overwhelming majority of women. In Indonesia, for example, 95 per cent of mothers breastfeed for more than a year. Much of the effort needed in the promotion of breastfeeding is positive reinforcement, so that where breastfeeding is still the norm, it will continue to be so.

Growth Charts

Growth charts, in common with the other technical "breakthroughs" in child nutrition and health are not revolutionary in concept. Charts on which a child's weight is systematically plotted, and other measuring aids for monitoring child growth, have existed since the dawn of modern pediatrics. Yet the use on a much wider scale of aids such as simple charts which mothers can keep in their homes as a guide to proper child feeding could substantially reduce child malnutrition.

This is because most malnutrition is invisible. Consistent undernutrition, coupled with bouts of infection and diarrhoea, can retard a child's growth so gradually as to be unnoticeable to the mother. But a chart will reveal it to her, and there is evidence that in as many as half the cases of child malnutrition, inattention resulting from the problem's invisibility, rather than lack of food in the family, is the principal cause.

The use of growth charts to monitor children's nutritional status is becoming a more regular feature of UNICEF country co-operation. In several African countries, growth charts are used in mother and child health services: in Botswana, Ghana, Kenya, Malawi, Mozambique, Zambia and Zimbabwe, for example. But in most countries growth charts are used in small projects and have not yet been adopted on a national scale as part of community-based health services.

A most striking use of health charts, profiled on the next page, is in Indonesia, where about one third of the child population is covered. The message conveyed is that a rising line of dots is good; a level line is a warning—more food is needed; a declining line calls for more food and a visit to the health centre. The first full evaluation of the Indonesian growth chart programme will be made in 1983.

In Thailand, community-based programmes utilizing growth charts already cover a million children. Pilot projects, or integrated area projects, involving locally-based nutrition and community health workers and the use of growth charts, are being supported in Ecuador, Pakistan, and Sudan. ☐

Weighing in: an emotional experience — INDONESIA

Istianah was apprehensive as she brought her 17-month-old daughter Eni to the weighing post. Eni had been ill and she was afraid that her child would record a loss. For Istianah, the 22-year-old wife of a farm labourer, and other mothers in the village of Jombor in the highlands of Central Java, the weight of their children has become almost an obsession.

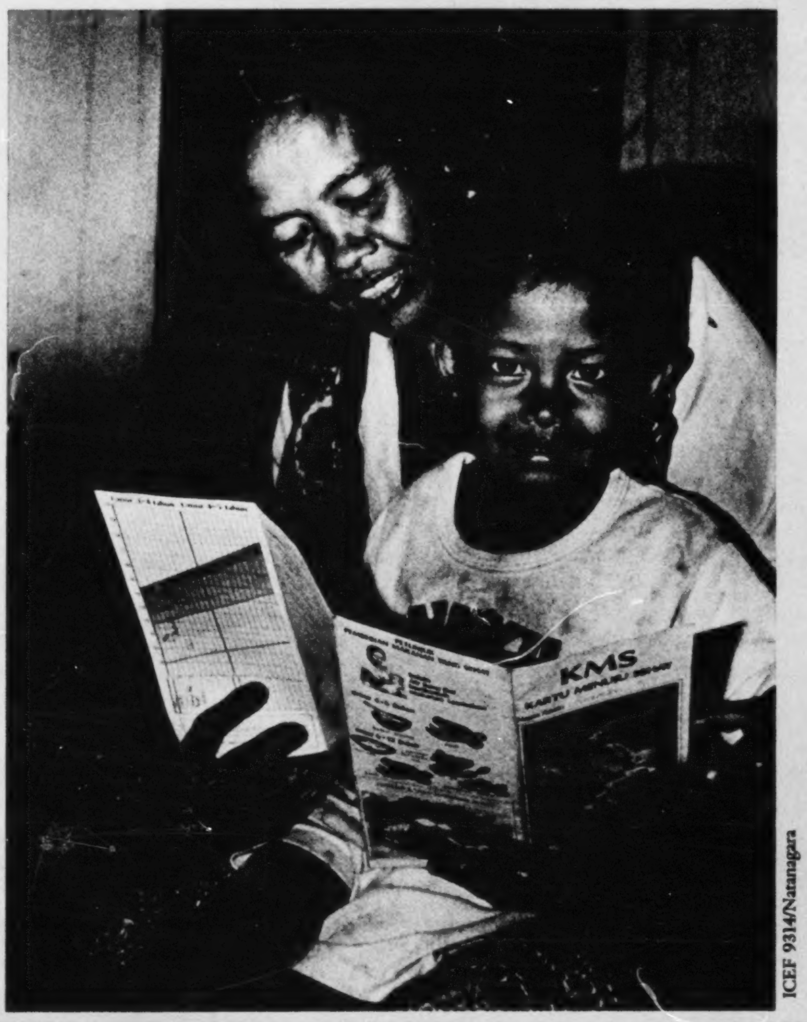
Eni, in common with one third of the children weighed that day, did in fact lose weight: almost half a kilo. But Istianah was not worried. She knows that a weight loss means that she should feed her child more and better food. But some mothers, like Tumirah who brought her 13-month-old daughter, are not so knowledgeable. And, as a nutrition cadre noted, perhaps one or two will not come back to next month's weighing session because of their disappointment.

The crux of what has become an emotional experience for many mothers of Jombor village is the *Kartu Menuju Sehat*—literally "Towards Good Health Card"—KMS for short. Each mother clutched her KMS as she brought her child for the monthly weighing. A continuous weight gain means a healthy child, while a loss indicates an illness or inappropriate feeding. Developed with UNICEF assistance, the KMS also provides information on breastfeeding and child feeding; on the use of sugar-salt oral rehydration solution (oralyte); and has schedules for vitamin A distribution and the series of immunizations needed to protect the child. Mothers take their KMS home with them and follow its guidance, together with the counselling from the nutrition cadres, on the healthy upbringing of their children.

In Jombor village, the 20 volunteers trained as nutrition cadres have done their work well. Mrs. Riefati, a senior high school graduate and a mother of three, was one of the first. There are 205 children under five years in the village, and of these, 177 have KMS cards. "On a good weighing day, barring rain or other problems," she says proudly, "virtually all the children are weighed." Not all the mothers really understand the meaning of the growth chart; some even lose them. But these difficulties notwithstanding, the chatter and hubbub of over 100 noisy children during the session are a good sign that things are going well.

And not only with the weighing. Dr. Endang from the sub-district Health Centre notes with satisfaction that the village has also distributed vitamin A and oralyte as required, and carried on with nutrition education and supplementary feeding. She is particularly proud that in Jombor village the vaccination teams for child immunization have adjusted their visits to coincide with the weighing schedule, and the results of their work have been recorded in each child's KMS.

Jombor village is in a poor area with a per capita income of about $80 per annum. Its Infant Mortality Rate is listed as 32.5 per thousand live births. Even if the statistics indicate some under-reporting—as Dr. Endang herself admits—it is nevertheless a far cry from the national IMR of 98 per thousand. The figures show what can be done by a really well-planned nutrition programme.



ICEF 9314/Natanagara

Other basic services for children

The opportunities described in the previous section on health and nutrition could spearhead a revolution in child health and child survival. But however important in themselves, they are not sufficient to bring this about without action across the whole range of related basic services, essential if any such "revolution" is to be sustained. The full range of basic services in both rural and poor urban areas includes water and sanitation, formal and non-formal education, daycare for the pre-school child, training for youth, income-generating activities for women, and special attention to the needs of children suffering from disabilities. The participation of the community in the planning and implementation of basic services is seen as a fundamental prerequisite for their successful establishment.

WATER AND
SANITATION:
In 1982 UNICEF

- co-operated in programmes to supply safe water and improved sanitation in 93 countries: 41 in Africa, 18 in the Americas, 27 in Asia and 7 in the Middle East region
- completed 76,824 water supply systems, including 71,011 open/dug wells with handpumps, 566 piped systems with 359 motor-driven pumps, and 4,888 other systems such as spring protection, rain water collection and water treatment plants
- benefited some 13.6 million persons (40 per cent of them children) from its rural water supply systems
- completed 126,819 excreta disposal installations benefiting some 934,600 people

Clean water and sanitation

Water-borne and water-related diseases, in conjunction with the debility caused by malnutrition, claim the lives of an estimated 20,000 to 40,000 infants and children per day in the developing countries. If, in 1982, the targets of the International Drinking Water Supply and Sanitation Decade (1981-1990)—clean water and sanitation for all—still seemed distant, there were grounds for encouragement as more and more countries, despite their economic difficulties, drew up concrete plans for moving towards the Decade's goals.

In 1982 UNICEF expenditure on water supply and sanitation programme components came to $60.1 million. The installation of simple, low-cost water supply systems predominated, so as to ensure that only minimal problems would subsequently be encountered with their operation, maintenance, and the replacement of parts. The majority consisted of dug wells or drilled boreholes fitted with handpumps; protected springs; rainwater collection; and gravity-fed piped systems.

For excreta disposal, simple low-cost options were also emphasized. In Bangladesh, in a government programme with which UNICEF has co-operated, 58,000 water-sealed latrines for family use have been produced and sold at low cost, and the steady increase in the demand for latrine units reflects a growing awareness of the interconnection between adequate sanitation and good health. In Tanzania a rural sanitation project was launched in Wanging'ombe to complement a village water supply programme whose installation has been completed. Initiated on a self-help basis, the Wanging'ombe project calls for the installation in 50 villages of a double-vault compost latrine called the ***utafiti***, and two types of low-cost "ventilated improved pit latrines"—or VIPs.

Water supply and sanitation projects cannot be effective in isolation from other programmes, and an important trend in 1982 was to integrate them as components in health programmes and with basic services in general. During the year, national workshops were held in Ethiopia, Mozambique

ICEF 9315/Gubb

A plentiful water source nearby eases women's domestic burden and enables them to raise their children in a clean environment. Ethiopian children man the village pump.

Water comes to the "place of wasps"

MOZAMBIQUE

Selina Arafel lives in a village called Itanda on the Mueda plateau in northern Mozambique. She rarely washes herself or her children. Cristina Nculungua, however, who lives only 20 kilometres away in the village of Namaua, washes herself and her children thoroughly every day. The reason is obvious. It takes Selina five and a half hours to fetch the same bucket of water that Cristina takes fifteen minutes to collect from the standpipe in her village.

The Mueda Plateau, just south of the Tanzanian border, is home to about 90,000 people. One of the fonts of Mozambican nationalism, it was the scene of fierce fighting during the struggle for independence. The plateau is fertile and, lying at an elevation of 1,000 metres, has a comparatively healthy climate. Unfortunately, it is lacking in streams and wells and traditionally women have had to trudge many miles to fetch water from springs down the bordering escarpments. Even the names of Selina's and Cristina's villages emphasize the preoccupation of the local people with their water problems. *Itanda* means "marsh" and *Namaua* means "place of wasps" after the insects that swarmed around the old water hole.

Once having won their independence, the people looked to the new government to help them overcome their water shortage. Their hopes were soon rewarded. A $3.5 million project, half of it paid by UNICEF, was undertaken to pump water from springs located at the edge of the plateau to standpipes in 35 villages. The project is not yet complete, but already its impact on the lives of women and their children is dramatically evident.

The village of Itanda, where Selina Arafel lives, has not yet been reached by the new water supply system. Selina must walk 10 kilometres to the edge of the plateau, and then continue down the escarpment on a winding trail stretching 200 metres below to the nearest spring. Then she must struggle back with a 20 or even 30 litre can on her head. It is not a trip you make every day, and every drop of water is precious.

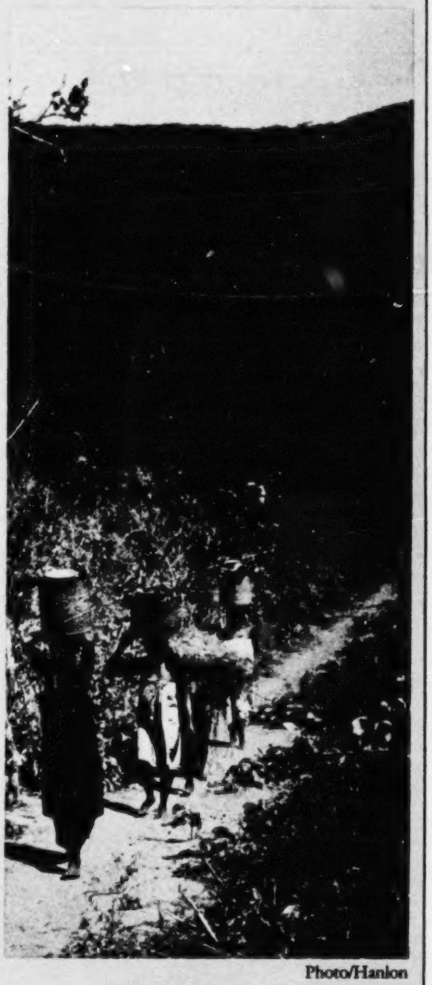
By making the trek four or five times a week, she can barely provide each of the five people in her family with four litres—about a gallon—a day. This must suffice for drinking, cooking and cleaning. Not surprisingly, she rarely washes herself or her children. Recently, Selina started getting her water from a standpipe in a nearby village. The queues are so long that it still takes her five and a half hours to make a round trip, but at least the water is clean instead of muddy—which she appreciates. And there are no lions about. In the year before the standpipe arrived in this village, two women were killed by lions at the old water hole.

Cristina Nculungua is in a very different position. The water standpipe arrived in Namaua in May 1981, and Cristina and her neighbours use an average five litres of water per day to wash their small children, while the women of Itanda use five litres per *month* for the same purpose. The effect is dramatic: in Itanda, about one child in 12 has heavily inflamed eyes, from infections probably caused by lack of bathing. In Namaua no child has inflamed eyes.

Villagers say that another gain is the time the women are able to save, and instead to devote to other activities such as attendance at the women's organization meetings. In villages with water, women are growing more nutritionally significant crops like groundnuts, for which they had no time before. And it appears that baby feeding has improved. Previously, babies still on the breast but too heavy to carry to the water hole, had to be left many hours without food.

Studies are still going on to determine the full impact of the water supply system on health. A conference, bringing together health and water specialists, is soon to be held on the plateau. But it already seems clear that there is no need for a major health education programme about the uses of water and the value of clean water. The women already understand its virtues, even if they have not yet fully changed all their health habits, built up over generations when water was scarce.

It seems that the biggest health gains have come from the savings in women's time, and this may guide the next course of development plans for Mueda. Many questions need answers, and they cannot all be supplied by the specialists. Just as the people joined in the struggle for their freedom, and for their water supply, they will join in the plans about what to do next.



Photo/Hanlon

and Sudan to seek ways of focussing on sanitation and health education in the context of other programmes. (A profile on a major water supply programme in Mozambique appears on the facing page.)

Another area of intensified activity is the development of management and organizational skills at regional, district and village level so that human resources can be used to the optimum to gain the full benefits of water supply and sanitation programmes. The poor progress in this area up to now has been identified as the main constraint to the attainment of the goals of the Water Decade. Consequently, in 1982 more emphasis was placed on the training of village pump operators and caretakers, sanitation and health promoters, and well diggers and drillers in many of the water and sanitation programmes in which UNICEF co-operates.

Access to safe water in adequate quantities, close to their homes, is essential to improving the lot of women. The involvement of women in both the planning and the implementation of water projects, so as to guarantee the projects' suitability for meeting their needs, has been made a feature of programmes in Zimbabwe and Philippines, among other examples. Attention is consistently being paid in the planning process to the need for education in personal cleanliness—such as washing hands—and food hygiene, and to the location of water points close to bath and laundry facilities.

Lack of adequate water supply and sanitation is a major cause of the high infant and child mortality in the spreading slums, shanty-towns and infested tenements of the developing world. For this reason, water and sanitation were increasingly emphasized in UNICEF's co-operation in urban services programmes. The introduction of water and sanitation components into urban programmes, begun in a small way five or six years ago, is now a feature of basic services programmes in urban areas in 45 cities and towns around the world.

UNICEF is taking full advantage of the International Water Decade to strengthen its co-operation with other agencies in this field. Along with the World Health Organization, the UN Development Programme and the World Bank, UNICEF is a member of the Governing Council of the International Reference Centre for Community Water Supply and Sanitation in the Hague. UNICEF is continuing its extensive field testing of handpumps for a UNDP-financed global project executed by the World Bank, and is also taking part in an international network for the collection, retrieval and dissemination of information on low-cost water and sanitation activities. During the rest of the Water Decade, UNICEF will continue to play a leading role in promoting public awareness of, and donor support for, the goals of the Decade. ☐

Formal and non-formal education

Poor enrolment levels, high drop-out rates, and low learning achievement still bedevil the school education system in all parts of the developing world. The outcome is reflected in high levels of adult illiteracy, particularly among women. This problem is especially acute in sub-Saharan Africa and south Asia. In parts of these regions, only two out of 10 children complete primary education, and illiteracy among women exceeds 90 per cent.

Given the well-established link between female literacy and the use of health and social service amenities, these factors seriously impede the effective spread of basic services. Without an expansion of educational opportunities both for children, and for their mothers and older sisters who never went to school, activities in the health, nutrition, and water supply context cannot have a major impact on infant mortality rates or fertility behaviour. For these reasons, formal and non-formal education both remain high priorities in UNICEF country co-operation. Excluding the educational components of health, nutrition, sanitation and other programmes, these activities accounted for $29.1 million, or 14 per cent, of UNICEF's programme expenditure in 1982.

UNICEF co-operates with countries in education in four major areas: the upbringing, care and education of the pre-school child; primary school education; the development of non-formal educational opportunities for children whom the school system has passed by, and for older girls and women; and the educational components of basic services programmes.

Efforts continued in 1982 to crystallize an approach, based on community involvement and resources, to meet the multi-faceted needs of the young child at a critical period of growth and development. Among slum-dwellers on the outskirts of Lima, Peru, a project providing health and education services for children includes training in income-producing skills for other members of the family. Residents of the area, with assistance from the health, education and labour ministries, have themselves constructed community centres, known as ***modulos***. Each consists of a pre-school education centre, a kitchen, a health

EDUCATION:
In 1982 UNICEF

- » co-operated in primary and non-formal education in 102 countries: 46 in Africa, 22 in the Americas, 26 in Asia and 8 in the Middle East region
- » provided stipends for refresher training of some 96,400 teachers including 66,800 primary-school teachers
- » helped to equip more than 80,200 primary schools, teacher-training institutions and 1,800 vocational training centres with teaching aids, including maps, globes, science kits, blackboards, desks, reference books and audio-visual materials
- » assisted many countries to prepare textbooks locally by funding printing units, bookbinding and paper

post, and a multi-purpose community hall. Over 160 health promoters, 600 pre-school teachers, and 200 "block" delegates have been trained. More than 12,000 children and their families have benefited.

In Malaysia, UNICEF has been supporting pre-school activities as part of the Sang Kancil integrated services project for the urban poor, and is now working with the government to establish appropriate pre-school education policies at the national level. An exchange of experience among developing countries in this field is being encouraged by UNICEF-supported seminars, workshops and study tours for educators from other developing countries.

UNICEF's priorities in support of primary education continue to be qualitative improvement, enhancing the relevance of subjects learned in school to the realities of children's lives, and reaching those in remote or deprived areas where the standard of education or the availability of school equipment and teaching services is comparatively low. Common to most UNICEF-assisted primary education programmes are: co-operation in courses designed to upgrade the competence of underqualified primary teachers; the adaptation of curricula to give greater emphasis to the most appropriate subjects; and the production of suitable instructional materials.

In India, for example, UNICEF is co-operating closely with the National Centre for Educational Research and Training (NCERT), and with state level institutions to support a national strategy for universal primary education. This vast programme includes an experimental project in community education based on primary schools; the decentralization of curriculum development to enable different parts of the country to develop their own "non-formal" approach to primary education; and special attempts to increase the chances of schooling for children of underprivileged groups such as Harijans and Tribals.

Projects specifically designated as "non-formal education" are usually those concerned with educational opportunities for women and young people outside the formal schooling system. Projects designed to train women in income-generating skills are also often designated as non-formal education programmes. In Ethiopia, for example, 10,000 women are attending short leadership courses conducted by home extension agents, whose task is to inspire and equip their fellow villagers to organize self-help activities. Skill-training courses are linked to the leadership courses, and the skills taught are those which are most likely to find a market in the particular locality.

Education is an integral part of the basic services approach. Besides the training of professionals and para-professional workers, most basic services programmes in which UNICEF co-operates include general consciousness-raising, and community education in health, nutrition, sanitation, and child-care. In Sudan, 3,400 community health workers and 4,000 village midwives have been trained and equipped with simple clinical instruments and a renewable supply of basic drugs. They serve a rural population of 3.4 million.

In Nicaragua, a network of nutrition promoters recruited from their communities has been set up with special UNICEF assistance provided by Norway. In Jamaica's St. Thomas Parish, a "child-to-child" programme has been developed based on the primary schools, where children are taught how to take preventive health actions to protect themselves and their siblings against disease. The children take home to their families the lessons they learn, enabling their mothers and their brothers and sisters to become more knowledgeable about health and child development. □

Many non-formal education programmes help older women make up for the schooling they missed as children. A literacy class in Lebanon gives such women confidence.

ICEF 9129/El-Azem

22

Do they think this is just a kitchen?

ICEF 8744/Nagarajan

Ompati, a 23-year-old wife of a prosperous farmer in northern India, believed so strongly in the new child care programme offered by the government that she went against the wishes of her husband's family to volunteer as a child care worker so that the programme could come to her village.

Dhandhlan is a relatively large farming village of almost 4000 people in the north Indian state of Haryana. A sizeable number of its people are Harijans, the lowest group in the Hindu social structure. Most are poor and work as farm labourers.

A few years ago the Government of India introduced an Integrated Child Development Services (ICDS) scheme to aid poor communities in rural areas, tribal districts and urban slums. The ICDS scheme was designed as a flexible community-based programme bringing a variety of health services to the people through the *anganwadi* or "child care courtyard".

When Ompati returned from her four-month training course as an *anganwadi* worker, eager to start work, she learned that the *anganwadi* built in the Harijan section of the village had no one to run it because no Harijan woman had enough education to qualify for the job. Bravely stepping over an old caste barrier, Ompati agreed to work there.

She began by visiting every home to record the vital statistics of each family. Of the 842 people in Dhandhlan, 159 were children of six-years-old or younger. Miscarriages were frequent, infant mortality was high.

Although she explained that one of the main purposes of the *anganwadi* was to care for each child's health, many mothers were shy or reluctant to send their youngsters. "Mothers refused to let me weigh their children," Ompati says. "They feared their children would fall sick if I put them on my weighing scales. I had to put my own child on the scale and give endless explanations before I was able to record their children's weight."

After much persuading, there are now about 70 children in her centre. They play with toys Ompati has taught their mothers to sew, and sing health messages in their nursery songs. Some children arrive just in time for the simple mid-day meal. "I get cross with their mothers. Do they think this is just a kitchen? I teach children many useful things besides providing a meal."

Susheel Varma, the auxiliary nurse/midwife attached to the local primary health centre, visits the four *anganwadis* in Dhandhlan regularly and gives the children their immunizations. If Ompati has time, she goes with Susheel on her visits to families in the neighbourhood.

In the afternoons, women and girls come to the *anganwadi* to talk about health, the importance of personal hygiene and environmental cleanliness, and cooking techniques for better nutrition. About 50 women and girls attend Ompati's functional literacy class. She is very hopeful. "The children in Dhandhlan look much healthier. There are fewer miscarriages, and fewer babies die now. These are changes I have seen with my own eyes."

In 1981 an All India Institute of Medical Sciences survey of ICDS projects around the country found that almost half the children in the communities covered were enrolled in the *anganwadis*. The proportion of severely malnourished children was cut by half. More than 300 communities are presently benefitting from this UNICEF-supported programme; there are plans to extend it to an additional 700 communities by 1984.

Urban basic services

ICEF 9149/Wolff

A day-care centre in Tanzania. Pre-school facilities ensure that the children of working mothers can receive care and attention in a stimulating environment.

At its 1982 session, UNICEF's Executive Board reviewed a report entitled *Reaching children and women of the urban poor* (E/ICEF/L. 1440), which was based on information solicited during 1981 from 70 countries, and detailed case studies from nine countries: Brazil, Ecuador, Ethiopia, India, Indonesia, Malaysia, Mexico, Peru and Sri Lanka. This review recognized the need to attach a higher priority to the problems of the urban poor in UNICEF programme co-operation, given that the developing world's urban population is expected to increase from 840 million in 1975 to 2.1 billion by the year 2000.

While it is still true that most developing countries are predominantly rural, and it is in the countryside that most of the disadvantaged low-income people are to be found, urban problems no longer affect only a small proportion of women and children. In addition, they are the family members most susceptible to the ill-effects of living in crowded and insanitary conditions. Malnutrition levels can be very high, and in the absence of family support systems which rural life normally provides, urban children are particularly vulnerable. Survival in the city requires cash to a much greater extent than in rural areas, and incomes in the informal sector, on which most of the urban poor depend, have suffered as a result of the world economic recession.

UNICEF continued to expand its urban activities in all the developing regions during 1982, in the light of the action taken at the May Board session which opened the way for more extensive co-operation. Emphasis continued to be placed on childhood malnutrition, the situation of women, pre-school and day-care services, responsible parenthood and family planning, abandoned and disabled children, and the provision of adequate water and sanitation facilities.

In the Americas, where the rate of urbanization is the highest among developing regions, there were particularly noteworthy new initiatives. Eight of the more developed countries of Central and South America have already reached 74 per cent urbanization, and rural-urban migration continues throughout the region. Political leaders are giving greater attention to the problems of urban poverty, and governments are taking some measures to alleviate the wretched conditions which many women and children are obliged to endure in slums and shanty towns.

In Mexico the World Bank is financing an urban and regional development project in the Isthmus of Tehuantepec, including parts of three states: Tabasco, Chiapas and Vera Cruz. UNICEF will add resources to those made available by the Bank to improve living conditions among the poorest people in the project area, with an emphasis on community development. One feature will be access to credit.

A consortium of Guatemalan non-governmental organizations has joined with the government and UNICEF to provide support for income-generating activities, health and nutrition, training, education and legal aid for community-based micro-projects in five urban areas.

To strengthen the capacities of UNICEF's staff and government officials, as approved by the Board in 1982, a series of applied workshops have been held. As a result of one of these, held in Sri Lanka to review management experience in six urban basic services programmes in Asia, a report entitled *The Management and Delivery of Urban Basic Services* has been issued. In response to the problem of malnutrition among children in urban areas, UNICEF staff from Africa, Asia, and Latin America met in Port-au-Prince, Haiti, for a working group review with officials from Haitian organizations active in this area. (A profile on UNICEF's programme in Port-au-Prince appears opposite.)

A landmark international conference was held in Colombia on urban primary health care by the Andean countries. The meeting was jointly organized by UNICEF and the Colombian Ministry of Health. Priority was placed on the need for rapid development of community-based health services in poor urban areas.

The plight of abandoned children is of special concern in many urban areas, particularly in the Americas, where there are thought to be as many as 30 million children eking out an existence in city streets without support from their families, and five million living entirely in the streets by day and night. UNICEF, in collaboration with governments and private organizations, is searching for low-cost methods of dealing with this problem. The Canadian National Committee for UNICEF and the Canadian International Development Agency (CIDA) have agreed to fund a special two-year programme to explore some of these methods in Brazil. Inextricably bound to the problems of urban poverty in general, the problem of abandoned children does not lend itself to easy solutions. □

“Help us to keep the neighbourhood clean”

Mrs. Aidenaire Carm lives in Port-au-Prince, and makes what must be euphemistically called her living buying bananas in the market, and re-selling them, peeled. Her only customers are her neighbours in La Saline, one of the city's poorest slums, who like herself are trying to make ends meet in the most marginal of occupations. She is the only provider for her four children. Her husband, she says: “has abandoned his homeland. Who will help me now?” she laments. “Who will give me food?”

Aidenaire Carm came to Port-au-Prince with her family when she was a small girl. Her parents were forced off the land, victims of the relentless erosion which has blighted Haiti's hills and valleys and depleted the soil's fertility. The family fetched up in the city's slums in search of a livelihood.

La Saline is one of the worst. Like many of the other slums, it is situated on reclaimed land only just above sea level. When it rains heavily, the water pours down the steep hillsides of uptown Port-au-Prince, sweeping the city's detritus before it, and ends up feet deep among the shacks and hovels.

Charcoal and its residues permeate every corner of La Saline. The ankle-deep mud is half composed of ash and cinder, and the tin huts are black with the grime of countless fires and cooking braziers. More unpleasant still, and more hazardous to health, are the pools of stagnant water and piles of putrefying garbage—and worse—which litter the ground. Plaintively, a crooked notice beside an open-ditch reads: “Help us to keep the neighbourhood clean.”

In the past year UNICEF and the Ministry of Social Affairs have begun work on the first co-ordinated government-backed programme to upgrade the living environment in the slums. There are many non-governmental groups, church and lay, running programmes of all descriptions in different slum areas. But they need to be synchronized: the whole jigsaw of social ills must be seen as a piece and tackled as a piece.

Even within the Carm family the problems are interlocking. Aidenaire Carm is illiterate and unequipped for any job requiring skills or training. Her 15-year-old daughter has turned to promiscuity as a way of helping out. Her brothers and sister, like most of the children that play barefoot in the narrow alleyways, all manifest some sign of the neighbourhood's ill-effects: sores, a skin rash, unusual thinness, a persistent cough. Small wonder that Aidenaire Carm cites “the problems of life” as her most persistent preoccupation.

The UNICEF-supported programme, still in its earliest stages*, is trying to help the slum communities get rid of the stagnant pools, the noxious effluvia, the refuse and the all-pervading mud which must disappear before any dramatic improvement in health can be contemplated.

In St. Martin, a slum as bad as La Saline, drainage channels are being dug along the alleyways or widened where people have already constructed them in a makeshift fashion; wash-houses with latrines and showers are being built; and a system of garbage collection is being organized, using wheeled carts small enough to be towed along the wider lanes and left in prescribed positions until they need emptying.

The digging and the building, to which St. Martin's inhabitants are giving their labour, are among the first signs of improvement. But in the background, as yet invisible to the slum inhabitants, is the network of professional and technical support which the Ministry of Social Affairs now has in place. A trained team of community workers is ready to help people with the backing they need not only to dig drains but to run pre-schools, encourage pregnant women to go to the ante-natal clinic, and enrol a girl like Aidenaire Carm's daughter in a course that would enable her to earn a less demeaning living.

ICEF 9316/Black

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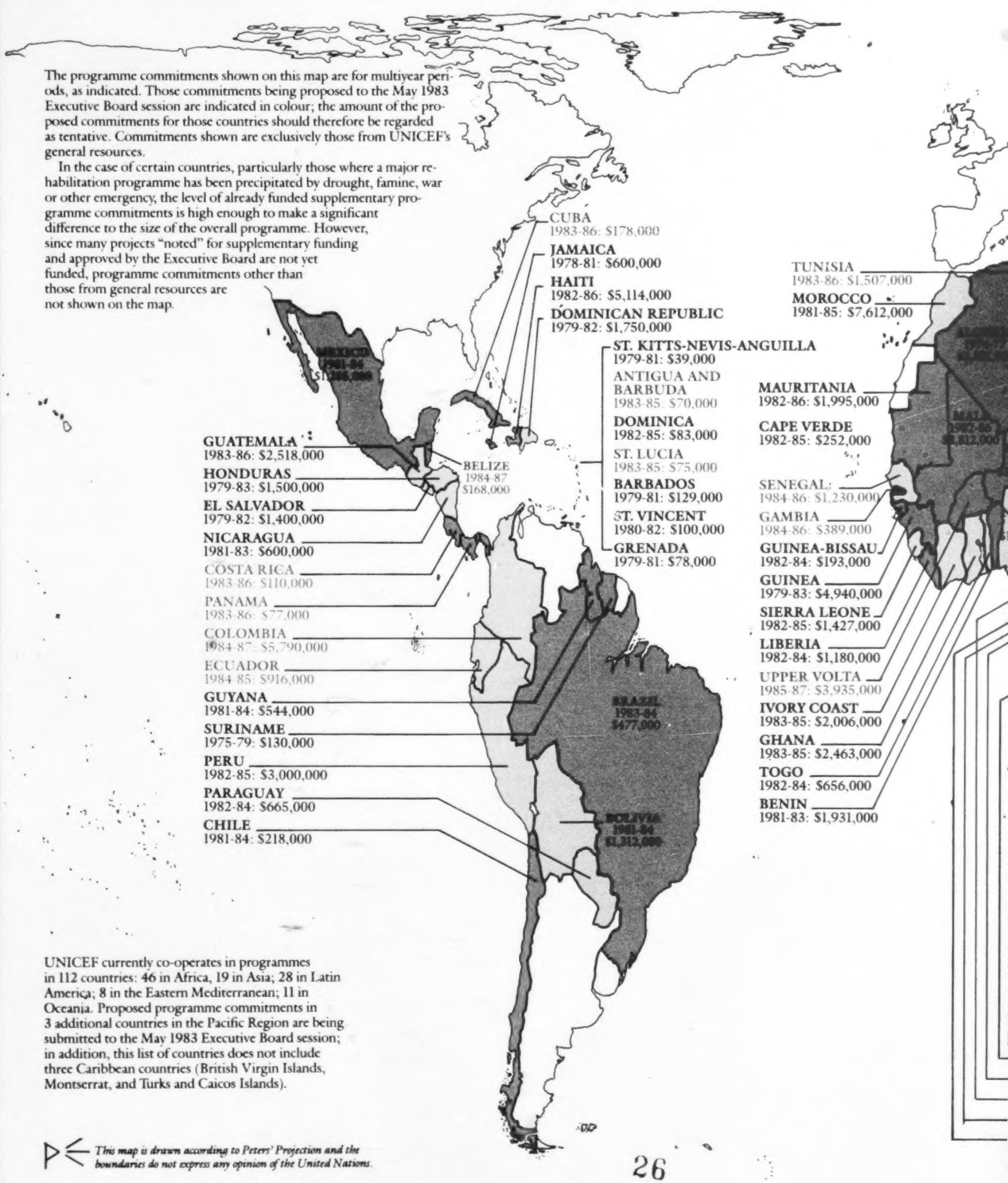
*The urban services programme in Port-au-Prince is “noted” for supplementary funding, which has not yet materialized. The programme needs a donor, therefore, if implementation is to go forward on schedule.

UNICEF in action: programme co

The programme commitments shown on this map are for multiyear periods, as indicated. Those commitments being proposed to the May 1983 Executive Board session are indicated in colour; the amount of the proposed commitments for those countries should therefore be regarded as tentative. Commitments shown are exclusively those from UNICEF's general resources.

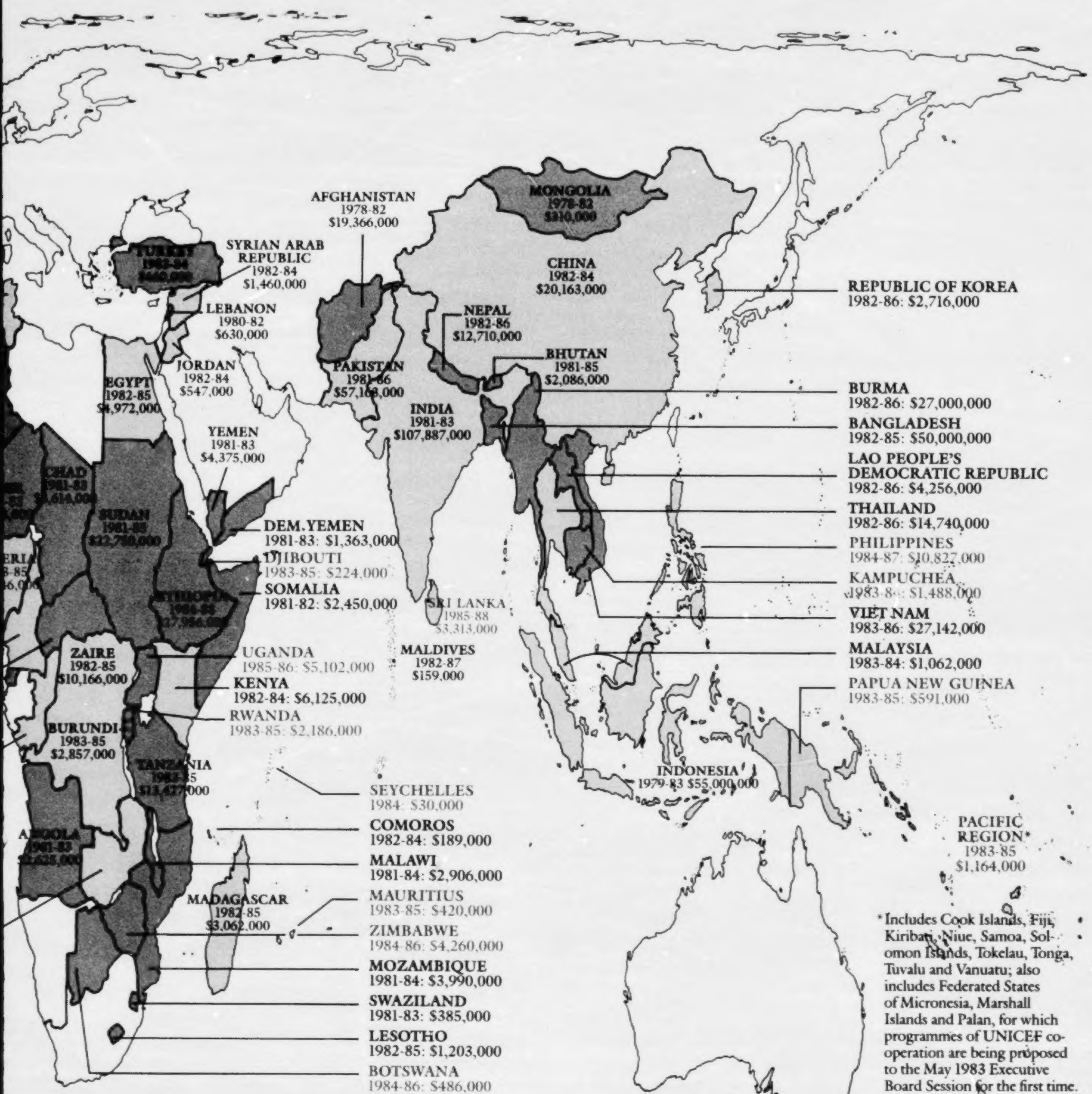
In the case of certain countries, particularly those where a major rehabilitation programme has been precipitated by drought, famine, war or other emergency, the level of already funded supplementary programme commitments is high enough to make a significant difference to the size of the overall programme. However, since many projects "noted" for supplementary funding and approved by the Executive Board are not yet funded, programme commitments other than those from general resources are not shown on the map.


CUBA
1983-86: $178,000
JAMAICA
1978-81: $600,000
HAITI
1982-86: $5,114,000
DOMINICAN REPUBLIC
1979-82: $1,750,000
ST. KITTS-NEVIS-ANGUILLA
1979-81: $39,000
ANTIGUA AND BARBUDA
1983-85: $70,000
DOMINICA
1982-85: $83,000
ST. LUCIA
1983-85: $75,000
BARBADOS
1979-81: $129,000
ST. VINCENT
1980-82: $100,000
GRENADA
1979-81: $78,000
MEXICO
1981-84
$1,288,000
GUATEMALA
1983-86: $2,518,000
BELIZE
1984-87
$168,000
HONDURAS
1979-83: $1,500,000
EL SALVADOR
1979-82: $1,400,000
NICARAGUA
1981-83: $600,000
COSTA RICA
1983-86: $110,000
PANAMA
1983-86: $77,000
COLOMBIA
1984-87: $5,790,000
ECUADOR
1984-85: $916,000
GUYANA
1981-84: $544,000
SURINAME
1975-79: $130,000
PERU
1982-85: $3,000,000
PARAGUAY
1982-84: $665,000
CHILE
1981-84: $218,000
BRAZIL
1983-84
$477,000
BOLIVIA
1981-84
$1,312,000
TUNISIA
1983-86: $1,507,000
MOROCCO
1981-85: $7,612,000
MAURITANIA
1982-86: $1,995,000
CAPE VERDE
1982-85: $252,000
MALI
1982-86
$8,812,000
SENEGAL
1984-86: $1,230,000
GAMBIA
1984-86: $389,000
GUINEA-BISSAU
1982-84: $193,000
GUINEA
1979-83: $4,940,000
SIERRA LEONE
1982-85: $1,427,000
LIBERIA
1982-84: $1,180,000
UPPER VOLTA
1985-87: $3,935,000
IVORY COAST
1983-85: $2,006,000
GHANA
1983-85: $2,463,000
TOGO
1982-84: $656,000
BENIN
1981-83: $1,931,000

UNICEF currently co-operates in programmes in 112 countries: 46 in Africa, 19 in Asia; 28 in Latin America; 8 in the Eastern Mediterranean; 11 in Oceania. Proposed programme commitments in 3 additional countries in the Pacific Region are being submitted to the May 1983 Executive Board session; in addition, this list of countries does not include three Caribbean countries (British Virgin Islands, Montserrat, and Turks and Caicos Islands).

This map is drawn according to Peters' Projection and the boundaries do not express any opinion of the United Nations.

nmitments in the developing world


AFGHANISTAN
1978-82
$19,366,000
MONGOLIA
1978-82
TURKEY
SYRIAN ARAB
REPUBLIC
1982-84
$1,460,000
CHINA
1982-84
$20,163,000
REPUBLIC OF KOREA
1982-86: $2,716,000
LEBANON
1980-82
$630,000
NEPAL
1982-86
$12,710,000
JORDAN
1982-84
$547,000
PAKISTAN
1981-86
$57,168,000
BHUTAN
1981-85
$2,086,000
EGYPT
1982-85
$4,972,000
INDIA
1981-83
$107,887,000
BURMA
1982-86: $27,000,000
BANGLADESH
1982-85: $50,000,000
YEMEN
1981-83
$4,375,000
CHAD
1981-83
SUDAN
1981-85
$22,750,000
LAO PEOPLE'S
DEMOCRATIC REPUBLIC
1982-86: $4,256,000
THAILAND
1982-86: $14,740,000
DEM. YEMEN
1981-83: $1,363,000
DJIBOUTI
1983-85: $224,000
PHILIPPINES
1984-87: $10,827,000
ETHIOPIA
SOMALIA
1981-82: $2,450,000
KAMPUCHEA
1983-8: $1,488,000
SRI LANKA
1985-88
$3,313,000
VIET NAM
1983-86: $27,142,000
ZAIRE
1982-85
$10,166,000
UGANDA
1985-86: $5,102,000
MALDIVES
1982-87
$159,000
MALAYSIA
1983-84: $1,062,000
KENYA
1982-84: $6,125,000
PAPUA NEW GUINEA
1983-85: $591,000
BURUNDI
1983-85
$2,857,000
RWANDA
1983-85: $2,186,000
TANZANIA
1982-85
INDONESIA
1979-83 $55,000,000
SEYCHELLES
1984: $30,000
ANGOLA
1981-83
COMOROS
1982-84: $189,000
PACIFIC
REGION*
1983-85
$1,164,000
MALAWI
1981-84: $2,906,000
MAURITIUS
1983-85: $420,000
MADAGASCAR
1982-85
$3,062,000
ZIMBABWE
1984-86: $4,260,000
MOZAMBIQUE
1981-84: $3,990,000
SWAZILAND
1981-83: $385,000
LESOTHO
1982-85: $1,203,000
BOTSWANA
1984-86: $486,000

*Includes Cook Islands, Fiji, Kiribati, Niue, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu and Vanuatu; also includes Federated States of Micronesia, Marshall Islands and Palan, for which programmes of UNICEF co-operation are being proposed to the May 1983 Executive Board Session for the first time.

ZAMBIA 1981-84: $1,281,000

CONGO 1984-86: $334,000

SAO TOME AND PRINCIPE 1981-84: $192,000

UNITED REPUBLIC OF CAMEROON 1982-85: $1,722,000

EQUATORIAL GUINEA 1980-81: $200,000

CENTRAL AFRICAN REPUBLIC 1981-83: $1,817,000

- ▪ low-income developing countries where UNICEF accords a high priority for programme expenditure: least-developed countries, countries in special circumstances, and small countries with an at-risk child population (62 countries).
- ▫ middle-income developing countries, which receive the normal level of UNICEF co-operation (38 countries).
- ▪ high-income developing countries, which receive advisory and technical services rather than programming support from UNICEF (12 countries).

In the business of learning — INDONESIA

Reading, writing and arithmetic are fine things to learn, but just how do they help you make a living? On the island of Sulawesi in Indonesia, the Department of Education and Culture is attempting to provide an answer through a small business learning programme, called *Kejar Usaha*, which complements its adult literacy scheme.

The literacy programme, which is assisted by UNICEF, is carried out through learning groups of six to ten people, led by a tutor, and using a series of graded texts on literacy, numeracy and basic skills. It leads to a primary school equivalency examination.

The associated *Kejar Usaha* groups not only teach their participants to make better products—roof tiles, soybean cakes, floor mats, kerosene lamp chimneys, among others—but provide raw materials and equipment and help market the products.

Daka Daeng Kebo, a 50-year-old mother of eight, in Lengkese village, joined the adult literacy scheme in 1980. A year later, she became a member of a small business learning group specializing in the production of plaited mats of pandanus leaves, commonly used on both floors and walls in Indonesian houses. Having already plaited mats at home, she was a fast learner. She has doubled her output since joining the group and now finishes ten mats a month. With her newly acquired skills in reading and numbers, she can fill orders to the customer's specifications. She uses the additional income for extra food for the family and to pay for the education of her son who will soon graduate from junior high school.

Forty-five year old Patimang, a mother of nine, and her husband are members of a *Kejar Usaha* group that turns out foam cushions for sofa sets. "If I did not work here," she says, "my children would not be able to go to school."

"The word 'education' often scares people away from our mass education effort," says Hasbie Dahlan of the Non-Formal Education Communication Team. "In such cases we form a small business learning group first and through this make the participants aware of the importance of literacy, numeracy, and basic knowledge."

In itself the literacy programme has created increased awareness among women of ways to improve their families' welfare. Says Mrs. R. Daeng Nai, a young woman of 24: "I have seen changes in myself. I am no longer bashful. I can cook better. I even encouraged my husband to raise chickens." Coupled with the practical *Kejar Usaha*, the literacy scheme's potential for improving family living standards is great. It is literacy with a business-like purpose.

ICEF 9317/Natanajara

Women's activities

Since the 1975 declaration of a UN Decade for Women, and the widespread concern prompted by the Decade for a fuller realization by women of their critical role in social and economic development, UNICEF has been actively promoting women's participation at every level in all programmes of country co-operation. UNICEF emphasizes women's multiple roles as mothers, home managers, producers, providers for the family, and community leaders. Support for women's activities, including that in related fields such as pre-school, makes up a large part of the category of UNICEF co-operation described as "social welfare services for children", amounting to $15.2 million in 1982.

Recognizing that mothers have the primary responsibility for the upbringing of their children, UNICEF's early involvement in efforts for women was focussed on pregnant and nursing mothers in their nurturing capacity. This was later extended to activities connected with improved child-care, better home management, and the relief of daily drudgery. It was also recognized that women had an important role to play in community development.

Since the reviews carried out in UNICEF field offices during 1979, and reflected in the guidelines for programmes benefiting women approved by the Executive Board in 1980, UNICEF has given more emphasis to the training of women in skills for income-generation, acknowledging both the vital role that women play as providers for the family, and the fact that increasing numbers of women in many developing countries, particularly in urban areas, are heads of household. In many families, survival depends upon the woman working. Even in those cases where it does not, an increase of the woman's earnings tends to be spent on essentials such as food for the children, rather than on consumer goods.

In the past, UNICEF's support to the development of women's income-earning skills was devoted overwhelmingly to traditional activities such as handicrafts and sewing. These, as many of the women themselves complained, did not provide any significant additional income as they were marginal to the economic mainstream in which they were living. Activities such as poultry-raising, small livestock production, fishponds, market gardening and food-processing, are more economically viable as small-scale enterprises in rural areas, and are more usefully incorporated into the household economy.

The policy UNICEF now follows is to help establish women's economic activities on a sounder and more entrepreneurial basis. This usually involves training in management and marketing skills, as well as the identification of suitable products, for women's groups who have demonstrated the ability and enthusiasm to run a well-organized small- or medium-scale enterprise. They are given guidance in how to obtain access to credit, sometimes underwritten by UNICEF co-operation. The aim is to enable such groups to reach a point of self-development where they can manage to participate fully in the market economy. At the same time, so as to ensure that working women such as these can still look after their small children, attention is given to the provision of day-care, and to guidance for the mothers on sound child-rearing practices.

In Colombia, UNICEF is supporting a scheme to strengthen 50 small enterprises—known as *microempresas*—in the outskirts of Cartagena, 20 of which are run by women. The programme includes access to credit. Employment in the participating *microempresas* has increased by 26 per cent at a cost of $3,000 for each new job created, compared to $100,000 per job in Cartagena's modern industries.

As part of an urban anti-poverty programme in Malaysia, women were given training in needlecraft and tailoring. This has given birth to a batik soft-toy enterprise which recently won a contract from Malaysian Airlines for 3,500 toys per month. This is an example of how traditional skills and crafts, so long featured in women's programmes, can be transferred to the market economy. In Mexico and Ethiopia, sewing projects are developing into small garment manufacturing enterprises; in Swaziland, groups of women are being trained in metalwork and the production of construction materials; in Bangladesh they are being trained in business management and quality control.

SOCIAL SERVICES: In 1982 UNICEF

- co-operated in social services for children in 99 countries: 44 in Africa, 27 in the Americas, 20 in Asia and 8 in the Middle East region
- supplied equipment to more than 32,500 child welfare and day-care centres, 7,100 youth centres and clubs and 6,600 women's centres
- provided stipends to more than 53,100 women and girls for training in child care, homecrafts, food preservation and income-earning skills
- provided stipends to train some 48,800 local leaders to help organize activities in their own villages and communities
- provided equipment and supplies to 700 training institutions for social workers, and training stipends for 5,600 child welfare workers

For this Sudanese girl, sewing may be useful, but it will not be lucrative.

ICEF 9318/Gubb

Obtaining credit is a major hurdle facing women trying to enter the market economy. Many agricultural cooperatives are not open to women. As one of several initiatives in this field, UNICEF has established a project officer in the Regional Central American Bank for Economic Integration in Honduras to help strengthen the bank's social sector programming, and has established a fund to guarantee loans for enterprises initiated by women.

UNICEF is in the process of reexamining all its programmes related to economic activities for women, especially in the informal sector where most of the new employment opportunities are to be found. □

Childhood disabilities

Despite global economic difficulties in 1982, many UNICEF-assisted activities that were initiated during the International Year for Disabled Persons (1981) were expanded. National Commissions established during IYDP remained active in several countries, including Barbados, Brazil, Saudi Arabia, and Philippines. In India, at the request of the Government, UNICEF is dramatically expanding assistance in the field of childhood disabilities, including provision of vitamin A for the prevention of blindness.

UNICEF's co-operation in programmes of nutrition education and dietary supplements, the expansion of mother and child health services, together with immunization are important in helping to reduce preventable childhood disabilities, such as those caused by poliomyelitis and measles. Support is now growing for the early detection and treatment of impairments through existing community-based health, welfare and education services. In Brazil, for example, UNICEF co-operated in the publication of training manuals for use by family and community members to detect disabilities and take appropriate measures. Zambia, in the true spirit of UNICEF's approach, has set out to make all programmes receiving UNICEF support available to disabled children. In Barbados, disabled children now attend regular pre-school classes. Special training in prevention and early detection of disabilities was therefore provided to pre-school staff with UNICEF assistance.

UNICEF has collaborated with governments to carry out surveys on childhood disabilities in India, Lesotho, Nigeria, Pakistan, Sudan, Zambia and Zimbabwe. In Nicaragua, new links between the education and health services have been forged in dealing with disabled children, and many disabled children have been identified whose parents were either unaware of their disabilities or ashamed to acknowledge them.

Rehabilitation International closely co-operates with UNICEF in technical support on the prevention of childhood disabilities and the rehabilitation of disabled children. □

ICEF 9318/Wolff

A teacher in a special school in Colombia uses equipment to encourage a deaf child to speak. For many of the children in the developing world such special attention is unavailable. Since a 1980 Board decision, UNICEF has encouraged the identification and treatment of children with impairments in their communities, with the aid of simple low-cost measures which help preserve the normal cycle of child development and prevent the impairment becoming a major handicap.

Appropriate Technology

Improvement in the lives of children and women necessitates better use of technology related to food conservation, preservation, and other domestic activities. UNICEF is working with about 45 countries to help them develop low-cost technologies, using mainly local materials and skills, to meet village and home needs in health, nutrition and water supply and to alleviate some of the drudgery now involved in daily living.

The Eastern African Regional Office has been one of the prime movers in promoting appropriate technology within UNICEF. The village technology units in Nairobi and Nakuru, in Kenya, have pioneered the development or widespread promotion of a wide range of devices including maize shellers, improved traditional silos, cookstoves and cement jars for storing water and food. In Ethiopia, the UNICEF-assisted basic education programme is the entry point for appropriate technology activities. Development work has focussed on fuel efficient clay stoves, solar cookers and windmills.

In India UNICEF is assisting the development of multipurpose community bio-gas plants. The objective is to provide a low-cost alternative to traditional fuels, which are increasingly scarce, and at the same time to improve environmental sanitation by recycling animal, human and agricultural wastes. UNICEF is also assisting in the development of community bio-gas plants in Peru and Turkey. In

India, a technique for fortifying cooking salt with iron to control anaemia, and simultaneously with iodine to control goitre, is being developed.

In Indonesia, child weighing scales have been redesigned to suit local conditions. Improved methods of low-cost food preservation are being promoted, including better ways to smoke fish. In Nepal, where deforestation is a critical problem, UNICEF is helping to promote community woodlots and more efficient cookstoves, as well as alternative energy sources such as water mills and bio-gas plants. In Senegal better home presses to extract palm oil have been introduced and a quick composting technique for peanut shells and other organic wastes.

Co-operation with local non-governmental organizations is a prominent feature of appropriate technology activity in a number of countries. Among the NGOs supporting appropriate technology in Indonesia, for example, is the Indonesian Boy Scout movement, with a membership of seven million. ☐

International Youth Year (IYY)

The UN General Assembly has designated 1985 as International Youth Year (IYY) with three themes: Participation, Development and Peace. Opportunity to be of service is a direct and effective means of civic education for young people. IYY will offer an excellent opportunity for the energy of youth to be directed towards activities of benefit to children: for example, "Youth in Service to Children" in such fields as literacy, non-formal education, health and nutrition education, and environmental sanitation. Examples of the successful mobilization of youth for development activities can already be found in many developing countries including Chile, Ethiopia, Kenya, the Philippines and Upper Volta. UNICEF representatives in the developing countries will help and support National IYY Committees where they are formed.

Programme support activities

Project support communications

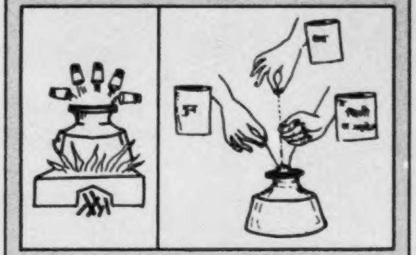
Weakness in the communication process at all levels is one of the major constraints to development. Project Support Communications (PSC) in the UNICEF context is the use of development communication techniques, ranging from interpersonal communication to mass media, in support of programmes. Due regard for PSC facilitates changes in attitudes and behaviour and the acquisition of new skills. PSC is an essential component of basic services for children, predicated as they are on community awareness and action.

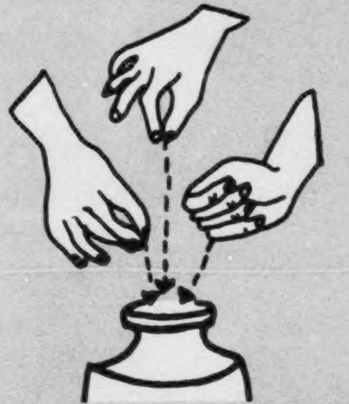
UNICEF gave high priority in 1982 to strengthening national capabilities in PSC. In the Eastern Africa Region UNICEF is assisting training institutions in nine countries to improve the communication skills of their extension workers. An important part of this programme is to develop texts and manuals suited to the African social and cultural environment, and to establish a network for exchange of experience and training materials among the countries of the region. In Nigeria UNICEF has helped the Federal Government to set up a development support communication unit to design practical strategies, produce and test communication materials, and train extension staff in PSC.

In the Philippines a survey revealed that misconceptions and lack of accurate information were crippling popular participation in a large child immunization drive. To correct this, UNICEF helped in communication training for more than 12,000 midwives. In Indonesia the large-scale Family Improvement Programme has included a strong PSC element from the beginning, based on the central message: "A healthy child is a growing child". UNICEF has collaborated in producing a wide variety of materials ranging from growth charts to reference manuals, training materials for extension staff, and mass-media back-up materials.

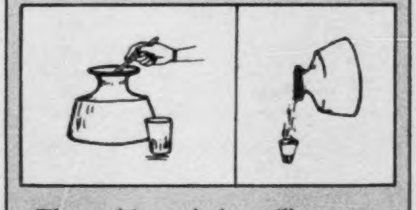
In other countries the mass media have been mobilized in support of programmes for children. In Jamaica UNICEF has assisted Radio Central in producing a 26-episode "soap opera" dramatizing family problems in agriculture, health, nutrition and education. In Brazil the successful

The following illustrations are taken from a Nepal study called "Communicating with pictures". The series was intended to show villagers how to make ORS.
The series was not comprehensible to any of the 89 villagers who saw it.



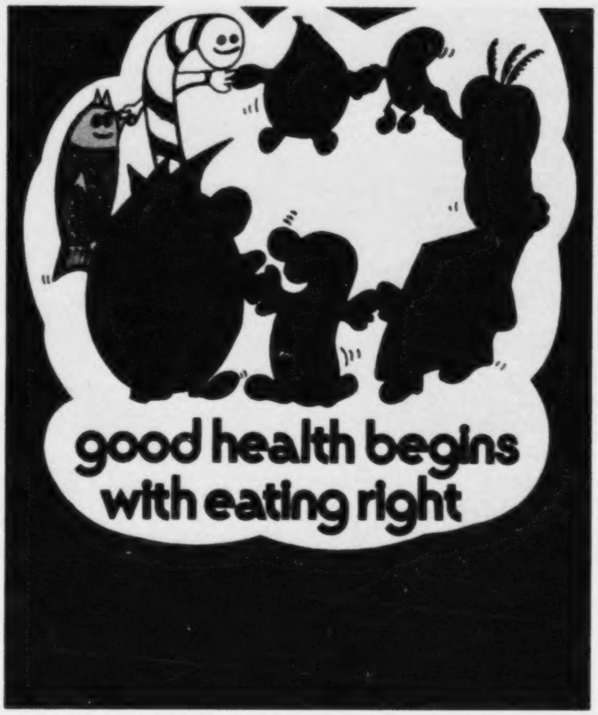


The second picture was separately shown to 410 villagers. Only 69 of them realised that it showed hands putting something in a pot.



The study's conclusion: villagers enjoy and respond to pictures, but interpretation is required.

From: "Communicating with Pictures," Nepal National Development Service/UNICEF


good health begins with eating right

Exercise book cover: Jamaican National Nutrition Education Programme

Every Thursday, one of Jamaica’s daily newspapers *The Daily Gleaner*, comes out with its special food supplement. Like cookery columns the world over, there is a strong appeal to culinary zeal and the adventurous palate. But unlike many a gourmet supplement, there are no elaborate recipes here, no dinner party menus or sophisticated ingredients. “Make rice very special”, suggests *The Daily Gleaner’s* cookery expert, and goes on to describe many cheap and nutritious ways to improve it: “Red and green rice”, “Hawaiian rice”, and “Herb Rice” are some of the most enticing.

In spite of the island’s lush reputation, Jamaica has a child nutrition problem, mainly in the urban slums but also in the countryside. Since a 1974 survey on the nutritional status of the under-fives and pregnant women, the national Nutrition Education Programme, with help from UNICEF, has been trying to tackle the problem in a variety of ways.

One way is through the media—press and radio. The nutrition education campaign reaches its peak every year in Nutrition Week. Mrs. Daphne Kelly, the communications officer at the Nutrition Education Department, says that the Week is useful for propaganda. “It helps keep the momentum up. All sorts of agencies and church groups do something special for the Week, and then become part of the regular campaign.”

Mrs. Kelly feels that over the years, the campaign has helped to make the cookery writers much more nutrition-conscious. In the *Daily News*, a special edition proclaims: “Eat right... be healthy”, and fills 16 pages with articles by Jamaican nutritionists. There is: “Gastroenteritis—a killer”, “Winning the weaning problem”, “Watch those food beliefs!” and in the centre, a banner headline reads: “WHY BREASTFEEDING IS A MUST”.

The radio is as insistent. Using an advertising agency, the Nutrition Education Department produces a number of 45-second slots, and buys air-time. Just before the news, a cheerful woman’s voice strikes up: “The newborn baby needs love and attention. Give the very best by breastfeeding, because breastmilk contains all the right ingredients.”

According to Dr. Michael Gurney, Director of the Caribbean Food and Nutrition Institute, not many children in the Caribbean are actually dying of malnutrition. The principal cause for anxiety is the age at which mothers wean babies, and the type of food they use to do so. The CFNI, run by the Pan-American Health Organization and supported by UNICEF, backs up the work of Nutrition Departments and Councils throughout the English-speaking Caribbean. Strong emphasis is given to the crucial infant and toddler period. Its efforts are echoed in Jamaica by the messages of the nutrition campaign.

Child nutrition problems, however, do not end at the weaning age. The Caribbean diet, fashioned by the old plantation life, is locked into wheat—bread and dumplings—which all has to be imported. Jamaicans are attuned to picking their food off the supermarket shelf rather than from the backyard plot. But prices are rising and wages are low. Some housewives, too ignorant to know better, buy cheap processed foodstuffs, advertised misleadingly as “nutritious”, rather than serve their children the produce they could raise in their own backyard.

Nutrition Week provides a publicity vehicle for the problem. But in the schools, and at the health clinics, nutrition assistants are repeating the messages all year round. In time, the slogan for the Week, “Eat right ... be healthy”, should become a shorthand phrase for a whole new set of dietary attitudes.

In a school in the Himalayan foothills of Pakistan, the teacher tells the children a folk tale called "The story of Nan Doshi". The children follow the story in a four-colour cartoon book reader.

Nan Doshi is a beautiful girl who dies suddenly on her wedding day. Her younger sister is secretly adorned to take her place. But when the young man sees that his bride-to-be has goitre, he refuses to take her hand and accuses the parents of cheating. The father then shows him the body of the dead girl, and explains that he did not want to send him away empty-handed. Upon which the bridegroom relents and accepts the sister as his bride.

The story is just one element in a carefully designed communications campaign now being carried out in northern Pakistan, with the co-operation of UNICEF, to combat endemic goitre by promoting the use of iodinated salt. In some sections of the valleys of Swat and Chitral, between 70 and 90 per cent of the people suffer from this disease.

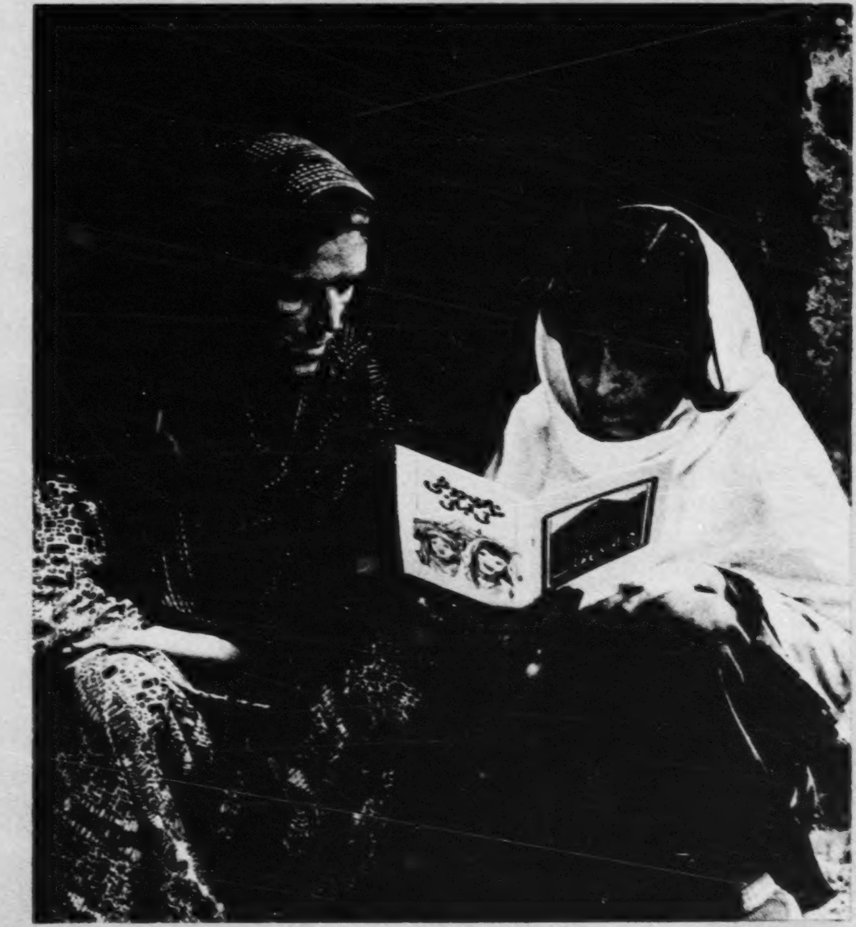
In the mid 1970's the Government obtained UNICEF assistance to set up the country's first salt iodinating plant. Iodinated salt has long been recognized as the most cost-effective way of combating goitre, but in Pakistan the new salt simply didn't sell at first. People were used to buying rock salt or plain crushed salt in the marketplace and saw no reason to switch.

An advertising agency was hired by the authorities to promote the sale of the new salt, but the agency's campaign had little effect. It relied almost entirely on printed materials (to be used in areas where almost no one could read); it featured negative pictures of goitre sufferers (all except one were women, thus giving the impression that iodinated salt was a *medicine* for a disease affecting women); and, on the up-beat side, featured posters of beautiful unveiled ladies, which were immediately torn from the walls in pious Moslem communities.

It was at this stage that UNICEF was called in to help with an ailing campaign. It was decided to go back to square one and re-design the promotional campaign. For the salt's packet design the face of a smiling boy was dropped—some people thought he looked like a ghost—and a mountainous landscape, with no human figures, was chosen.

Radio was selected as the principal medium to propagate the message through a combination of education and entertainment. Folk tales—the most popular form of entertainment—were adapted to the purpose, enhanced by appropriate verses from the Quran. Special materials for schools— like "The story of Nan Doshi"—were carefully integrated into the campaign.

The results have been most gratifying. Field evaluation in the test areas show that 80 per cent of the people have heard of Peshewari Salt—as the new salt is called, and that three basic messages have come across clearly: "Use Peshewari Salt"; "It's good for your health"; and "It protects from goitre". Sales rose rapidly in the first few months of the campaign. People are finally buying and using Peshewari Salt. Some day, when "The story of Nan Doshi" is told, the teacher will have to explain that goitre is a disease many younger sisters *used* to have once upon a time.



ICEF 9319/Azhar

campaign to enlist decision-makers in the promotion of breastfeeding has been followed up by a mass media campaign.

Two profiles which illustrate the importance and application of PSC within UNICEF-assisted programmes, in Jamaica and Pakistan, appear on the two previous pages.

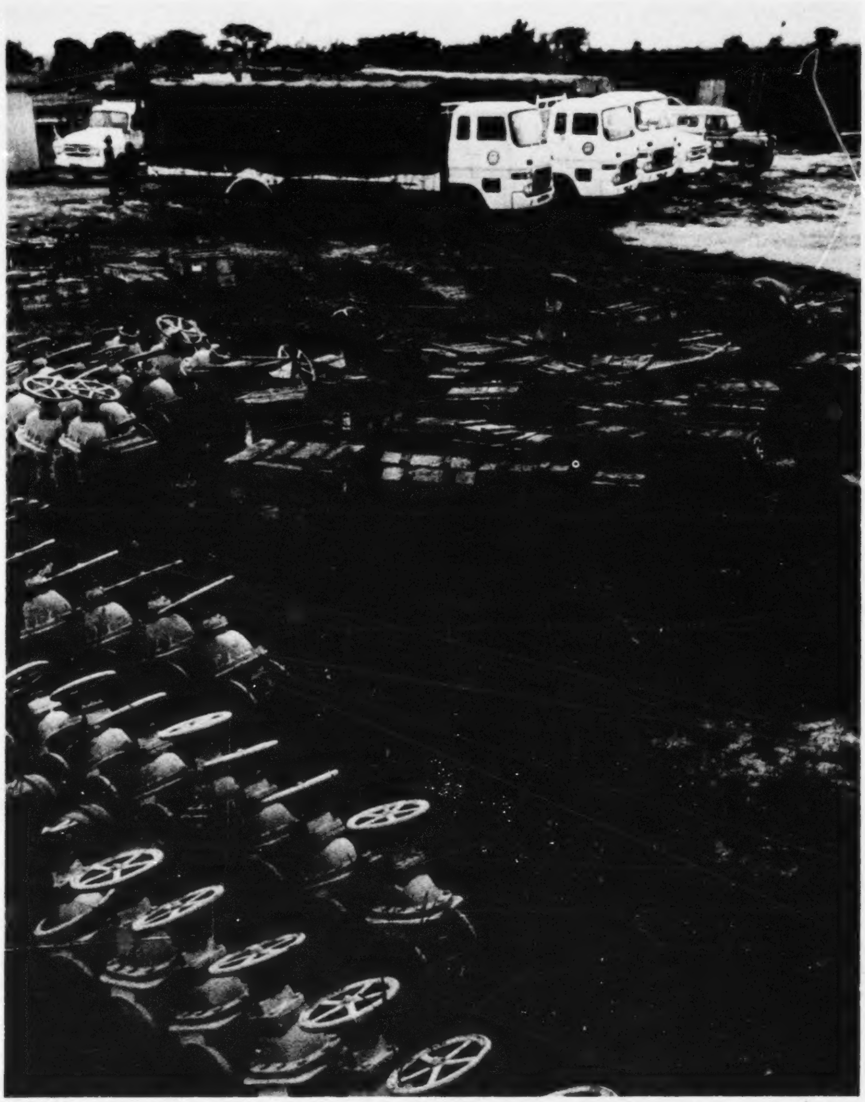
TCDC

Developing countries have much to gain by sharing experience and expertise in programmes for children and women, as in other areas of development. UNICEF actively supports such technical assistance among developing countries (TCDC).

UNICEF has helped arrange and finance a number of study tours so that government officials can see at first hand what other countries are doing to meet some of the major problems affecting children and families. Officials from various developing countries have studied integrated rural development in the Republic of Korea; hard-rock borehole drilling and handpump maintenance in India; and non-formal pre-school education in the Dominican Republic.

International seminars and workshops have also been supported by UNICEF to share knowledge and experience. An expert from one developing country may be recruited to help in a training programme in another: thus, with UNICEF support, a Nigerian expert was sent to help organize the training of traditional birth attendants in Egypt.

UNICEF has co-operated in strengthening institutions serving a number of countries: the University of the West Indies' Pre-school Development Centre, for example. Through its procurement policies, UNICEF encourages TCDC in regard to supplies and equipment. Particularly impressive is the story of the India Mark II Deep Well Hand Pump, developed in India with UNICEF support, and now regarded as one of the best designed and lowest cost products of its kind in many parts of the developing world.


ICEF 9322/Wolff

UNICEF actively supports TCDC, partly through procurement policies for supplies and equipment. Supplies are unloaded for a major water supply project in Tanzania.

Monitoring and evaluation

Careful monitoring and evaluation are essential to the success of programmes, and serve as a guide to future programming. Efforts continued in 1982 to develop national capacities in monitoring and evaluation, taking advantage of national expertise.

In 1982 three fields were selected for the systematic collection and synthesis of UNICEF experience: water supply and sanitation, training, and area development. Evaluations of technical and operational aspects of water supply systems were initiated in Burma, Nigeria and the Sudan, with the Nigerian exercise embracing the impact of water and sanitation on infant health and nutrition. The very extensive UNICEF-assisted training programmes in Bangladesh were chosen for special evaluation; and in the field of integrated programmes carried out in a particular area, those in Indonesia and the Dominican Republic received detailed attention.

UNICEF continued to help countries improve their capacity to collect and analyze social statistics in fields related to the needs of children and families in 1982. This included assistance to national household survey programmes in Nigeria, Ethiopia and Morocco. An important aim is to help countries establish baseline data against which progress in various social sectors can be monitored.

While progress has been made to improve the monitoring and evaluation of UNICEF-assisted projects, there are many constraints and difficulties. Evaluation is sometimes viewed as a threat rather than as a tool for better management. Nevertheless, it is becoming widely appreciated that support to monitoring and evaluation helps strengthen governments' abilities to make more cost-effective use of UNICEF assistance.

The activities of UNICEF's Special Envoy

UNICEF's Special Envoy H.R.H. Prince Talal Bin Abdul Aziz Al Saud of Saudi Arabia, continued his active work as an advocate for children. Travelling entirely at his own expense, the Prince made official visits to 12 countries, meeting with Heads of State and leading officials to discuss strategies for meeting the needs of children. His visits led to the formation of inter-ministerial committees for children in several countries.

In his role of Special Envoy for UNICEF, Prince Talal's missions took him to Djibouti, Niger, Senegal and Somalia in Africa; to Brazil, Colombia, Costa Rica, Haiti and Peru in the Americas; and to Bangladesh and Thailand in Asia. The Prince's advocacy also contributed, at the beginning of 1983, to the endorsement by Ministries of Health of the Arab Gulf State of the Executive Director's call for an attack on infant mortality through oral rehydration therapy, mass immunization, breastfeeding and growth charts, within the context of PHC.

AGFUND

The Arab Gulf Programme for the United Nations Development Organization (AGFUND), established in 1981 on the initiative of Prince Talal, stepped up its flow of development assistance channelled through UNICEF in 1982. By mid-May 1982, the close of its first fiscal year, AGFUND had allocated $25 million to UNICEF-assisted projects in 19 countries.

Subsequently AGFUND pledged to allocate 56.5 per cent of its governmental income to UNICEF. In addition all its income from private and other sources benefits UNICEF exclusively. Under this pledge AGFUND has since allocated $5 million to UNICEF-assisted programmes for women in 12 countries and to two regional projects; $6.25 million to support drinking water and sanitation programmes in 12 Asian countries. $1 million was also given for the provision of tents for earthquake victims in Yemen. A third allocation for water supply in Latin America and Africa will be considered at a meeting of AGFUND in May 1983.

An additional $12.8 million, raised by AGFUND from private and other sources, went to UNICEF's emergency operation in Lebanon and to its general resources.

AGFUND member states are Bahrain, Iraq, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates. ☐

ICEF 9121/UNICEF

UNICEF's Special Envoy, H.R.H. Prince Talal Bin Abdul Aziz Al Saud of Saudi Arabia, during a visit to a shantytown in Lima, Peru where UNICEF is co-operating in a project to provide community services for young children and their families.

Emergency relief and rehabilitation

The major emergency in which UNICEF was prominently involved during 1982 was the war in Lebanon and its aftermath. Immediately following the outbreak of hostilities on 6 June 1982, UNICEF in consultation with the UN Secretary-General launched an extensive relief operation for the tens of thousands of families left homeless or dispersed. As hostilities continued, the scale of the operation grew, and it subsequently developed into an even larger rehabilitation effort once hostilities had tapered off. At the height of the emergency, in July, a UN interagency mission estimated that 300,000 Lebanese and 83,000 Palestinians were in acute need of shelter, medical aid, food, water and sanitation.

Relief operations were hampered by the breakdown of logistics and communications throughout Lebanon. UNICEF's own country office in west Beirut was cut off from the rest of the country for many weeks, and the closure of seaports, airports and land routes made the delivery of relief supplies difficult. UNICEF established staging posts in Damascus, Syria, and in Nicosia, Cyprus. Staging posts were also set up inside Lebanon, in Baabda, east Beirut, and in Qana in southern Lebanon, where a sub-office had been dealing with reconstruction programmes south of the Litani river.

Working conditions were difficult as well as dangerous. Movement of personnel and relief supplies was severely hampered by fuel shortages and, during the long Beirut seige, by constant shelling.

By 15 June the first of four UNICEF-chartered airlifts transported relief supplies from UNICEF's Copenhagen warehouse to Damascus. Within a month, a total of four airlifts had transported altogether 160 tons of supplies. These consisted of blankets, towels, soap, oral rehydration salts, medical supplies, water purification tablets, antibiotics, children's wheelchairs, tents, camp stoves, K-Mix II (a therapeutic food), and cooking oil. One consignment of supplies was trucked by convoy from Damascus to the Bekaa valley in eastern Lebanon. Two further convoys took a total of 84 tons by a circuitous northern route for relief in west Beirut.

EMERGENCIES:
In 1982 UNICEF

- assisted 42 countries hit by disasters, 21 in Africa, 11 in Asia, 3 in the Middle East, 7 in the Americas, with the provision of immediate relief supplies
- expended $2,500,000 from the Executive Director's Emergency Relief Fund on tents, medicaments, water supply equipment, food supplements, and other relief essentials
- co-operated with other UN agencies in a major relief and rehabilitation programme in Lebanon, amounting to $60 million over the next two years
- provided emergency relief for earthquake victims in Yemen Arab Republic; to mothers and children affected by civil strife in Chad; and to persons expelled from Nigeria, returning to their West African home countries

Many additional tons of supplies, as well as small trucks and generators, were purchased in Damascus and various parts of Lebanon. In August, two UNICEF convoys from east Beirut were able to deliver directly to beseiged west Beirut several truckloads of food, water pipes and other essential supplies.

UNICEF's ability to move quickly in the emergency was matched by the prompt and generous response of the international community to the Executive Director's appeal in June for $5 million for an intensive 90-day relief programme. His later $32 million appeal for rehabilitation funds was even more generously supported.

UNICEF's ability to function effectively on the ground was made possible by the exemplary co-operation of other agencies, including UNIFIL (UN Interim Forces in Lebanon), UNDOF (UN Disengagement Observer Force), UNRWA (UN Relief and Works Agency for Palestine Refugees), the International Committee of the Red Cross, and the various national organizations that handled the final distribution of supplies.

Water delivery was identified as the highest emergency priority in Beirut and southern Lebanon. UNICEF's role in providing water supplies to west Beirut residents was perhaps its most important service to the city during the emergency. "Operation Water Jug" (see profile opposite) installed over 200 locally made steel water tanks at 50 distribution centres and at schools occupied by refugees and displaced persons. They were filled several times a day, each providing drinking water for 3,000 persons. Twenty-five non-functioning wells were rehabilitated through the installation of submersible pumps while new wells were drilled. Garbage and refuse collection services were provided to prevent disease. Following the massacre in the Sabra and Chatila camps, UNICEF assured a continuing water supply to the Palestinians remaining in the camps by trucking in water, cleaning wells, and installing pumps.

UNICEF undertook emergency repairs to restore water to many villages in the south. One of two major water systems serving 120 villages was almost totally destroyed, and UNICEF engaged local contractors to make temporary repairs to supply as many villages as possible.

Emergency repairs were made to a number of hospitals which had been damaged, especially in the south. UNICEF also helped equip the various temporary hospitals that were set up around west Beirut. Toward the end of July a child immunization campaign was launched as a protection against epidemics, with UNICEF supplying 50,000 doses of measles vaccine along with cool bags and vaccine carriers. Assistance was also given to the repair and re-equipment of damaged schools.

With immediate relief well underway, UNICEF prepared, in consultation with the Government of Lebanon and UN agencies, a two-year $60 mil-

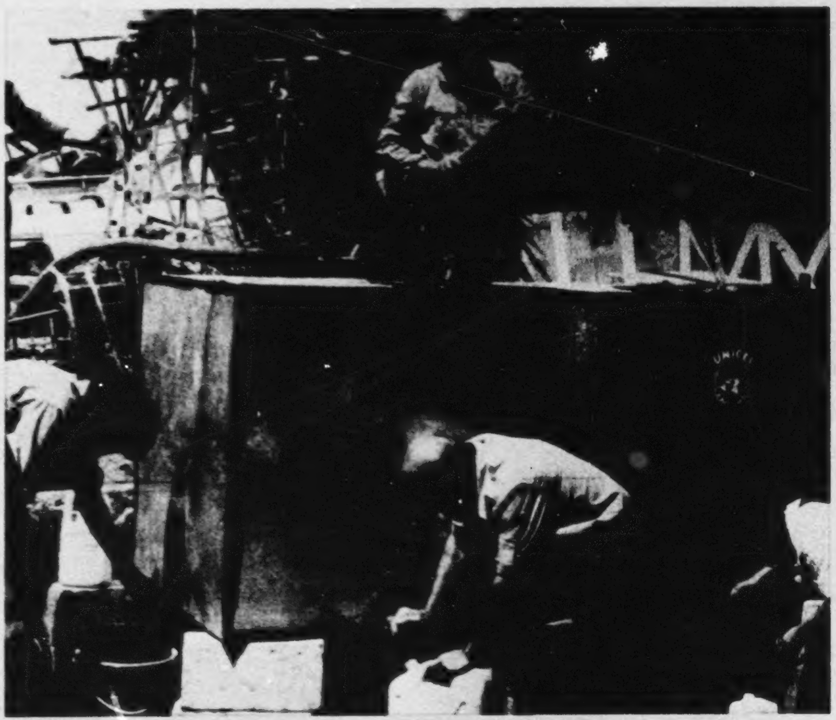
Operation Water Jug

"Were it not for UNICEF, west Beirut would now be full of thousands of people dying of thirst." So correspondent Bryan Boswell of *The Australian* reported to his paper in early July 1982. For three days the taps in the beleaguered Moslem half of the city had been dry. Someone on the Christian side had turned the water off at the main pumping station at Ashrafiye and would not allow it to be turned back on again.

Even if no one had died of thirst during this water emergency, which lasted clear through the hot summer months, deaths from typhoid fever and other water-borne diseases would have escalated as people resorted to water from drainage ditches and other contaminated sources. And the emergency hospitals set up to treat the wounded would have been crippled.

No wonder that Raymond Naimy, UNICEF's chief water engineer in Lebanon, was hailed as a local hero. Working round the clock with a crew of 14, Mr. Naimy managed within a few days to set up an emergency alternative system, codenamed "Operation Water Jug". He and his helpers assembled 200 thousand-litre steel tanks and set them out in groups at strategic points in the city. Two UNICEF tankers, taking water from existing artesian wells, made rounds 24 hours a day to replenish the tanks, where women and children queued with colourful plastic containers, buckets, cans or anything else they could commandeer.

Scurrying from one water emergency to another amidst bullets, bombings and strafings, Raymond Naimy acted as the *de facto* west Beirut water department. A shell hit his own living room one evening while he sat talking to his wife, but he shrugged the incident off and kept on working. With electric power as well as water shut off, Raymond Naimy scoured the city's apartment complexes for electric generators to keep the pumps going at the various wells on which Operation Water Jug depended.



ICEF 9201/Gerin

UNICEF drilling rigs were actually brought into city streets to drill for new water at safe depths. Throughout the emergency Raymond Naimy and his helpers kept enough water going to the communal tanks to keep west Beirut's family water jars full. Emergency generators and pump sets kept a steady flow of clean well water going at five temporary hospitals. As refuse piled up in the streets, further threatening children's health, UNICEF began clearing 250 tons of garbage daily.

The eventual restoration of water from the pumping station at Ashrafiye did not immediately solve west Beiruts's water problem. In September, Naimy and his helpers turned their attention to repairing damaged booster-pumping stations and water mains. And even in late November, when regular water supplies had been restored in central Beirut, Operation Water Jug remained the only source of drinking water in a number of poor, densely-populated areas.

Operation Water Jug was just one aspect of UNICEF's emergency work in Lebanon. As early as June, UNICEF airlifted 160 tons of emergency relief supplies to Lebanon, as well as locally purchasing and distributing over $1.4 million worth of critical supplies ranging from food and medicine to tents, blankets and water supply equipment. Helping restore water supplies in battle-scarred southern Lebanon was one of the most urgent matters. This included the repair of the bombed Ras El Ain pumping station near Tyre, serving villages with a population of over 200,000 plus 100,000 new refugees.

But Water Jug, in Beirut, caught the world's imagination. Cities in the Middle East have come under siege many times in the past. Often, water-borne epidemics killed more people than military action. This time it didn't happen. A few cases of typhoid were reported but no cholera and no epidemics. Raymond Naimy was indeed a hero.

lion programme for emergency reconstruction. This includes $28 million to be covered by the Lebanese Council for Development and Reconstruction with funds donated by Arab States, the remaining $32 million being covered by generous donations to UNICEF from governments, other agencies, UNICEF National Committees, and various non-governmental organizations.

The two-year programme, from October 1982 to October 1984, includes the continuing repair and rehabilitation of water-supply, health, and education facilities. Some of the engineering work required is very extensive, since serious damage to reservoirs, pumping stations and pipelines was widespread.

Considerable effort will go into a family rehabilitation programme based on community self-help. Recent events have uprooted families, many of whom have lost their possessions, sources of income, and security, and there are thousands of children whose physical and emotional well-being has suffered. A community self-help programme, which is planned to be carried out in co-operation with a number of local volunteer organizations, focusses on the care of orphans and children in foster families, family income-generating activities, and care for disabled children.

Other emergency assistance

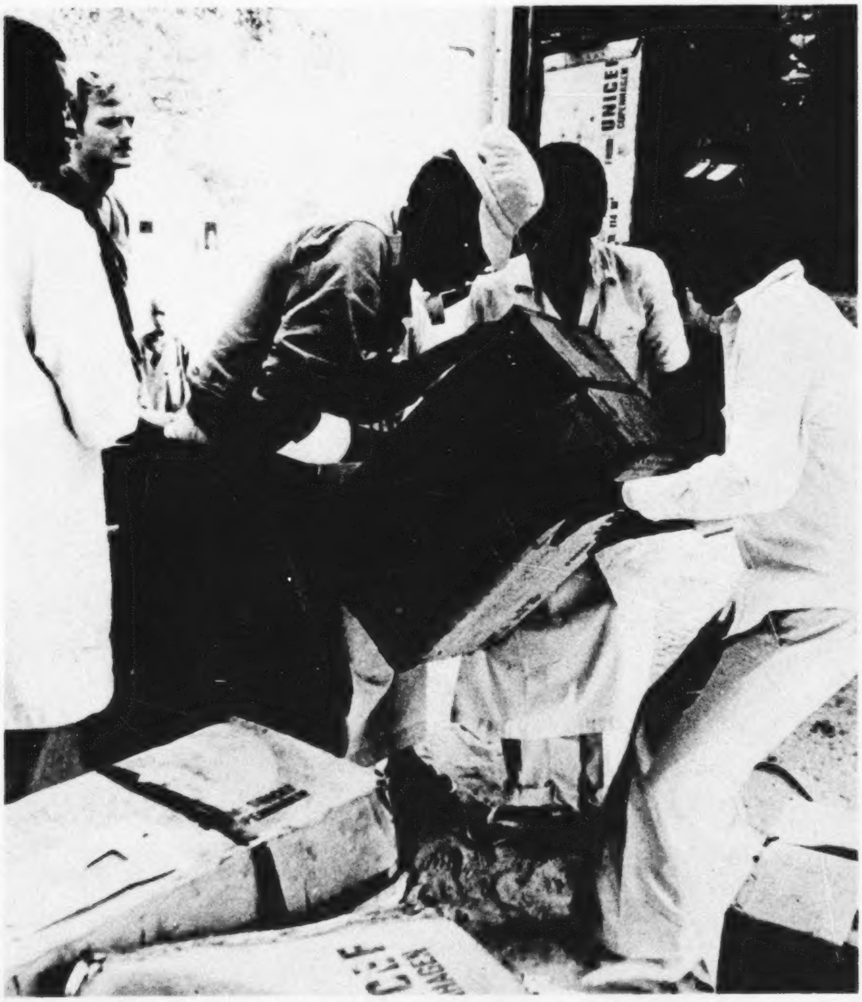
In Chad, thousands of women and children in the war-torn provinces north of the Chari river are in urgent need of food and medical care. Country-wide food shortages and pockets of acute hunger in the north have been reported by evaluation missions. In September, $400,000 was released from the Executive Director's Emergency Reserve Fund to help airlift food and drugs to Chad under a joint operation organized by the International Committee of the Red Cross with governmental assistance from France, Netherlands, UK, and USA. UNICEF's assistance is part of its ongoing relief and long-term co-operation in Chad.

Thirty-six hours after an earthquake ravaged much of Yemen in December, leaving an estimated 400,000 persons homeless, UNICEF began airlifting medical supplies, blankets, cooking equipment, tents and other necessities to the country. Assistance of $201,000 from the Emergency Reserve Fund was supplemented by special contributions totalling $420,000 from UN and bilateral sources. Through UNICEF's Special Envoy, Prince Talal of Saudi Arabia, AGFUND, the Arab Gulf development assistance group, subsequently pledged an additional $1 million to UNICEF for emergency relief purposes.

Early in 1983 UNICEF airlifted $300,000 worth of medical supplies to Ghana, Togo, and Benin to replenish medical stores depleted by the influx of foreign workers and their families expelled from Nigeria. More than half the supplies went to Ghana. As the return of the repatriated workers will put a heavy strain on the none-too-strong basic services structure in the countries absorbing the influx, further UNICEF assistance will aim at strengthening existing programmes for mothers and children.

Other emergency aid financed by the Emergency Reserve Fund in 1982 provided for the needs of refugee children in Rwanda and Uganda; and for relief to victims of drought in Botswana, Mozambique, Mauritania, and Cape Verde; floods in Benin, Democratic Yemen, Madagascar, India, Sri Lanka, Honduras, Guatemala, and Nicaragua; typhoons in Viet Nam and Tonga; an outbreak of meningitis in Zambia, diarrhoea and cholera outbreaks in the Maldives, and rehabilitation activities in China.

□



ICEF 9320/Murray-Lee

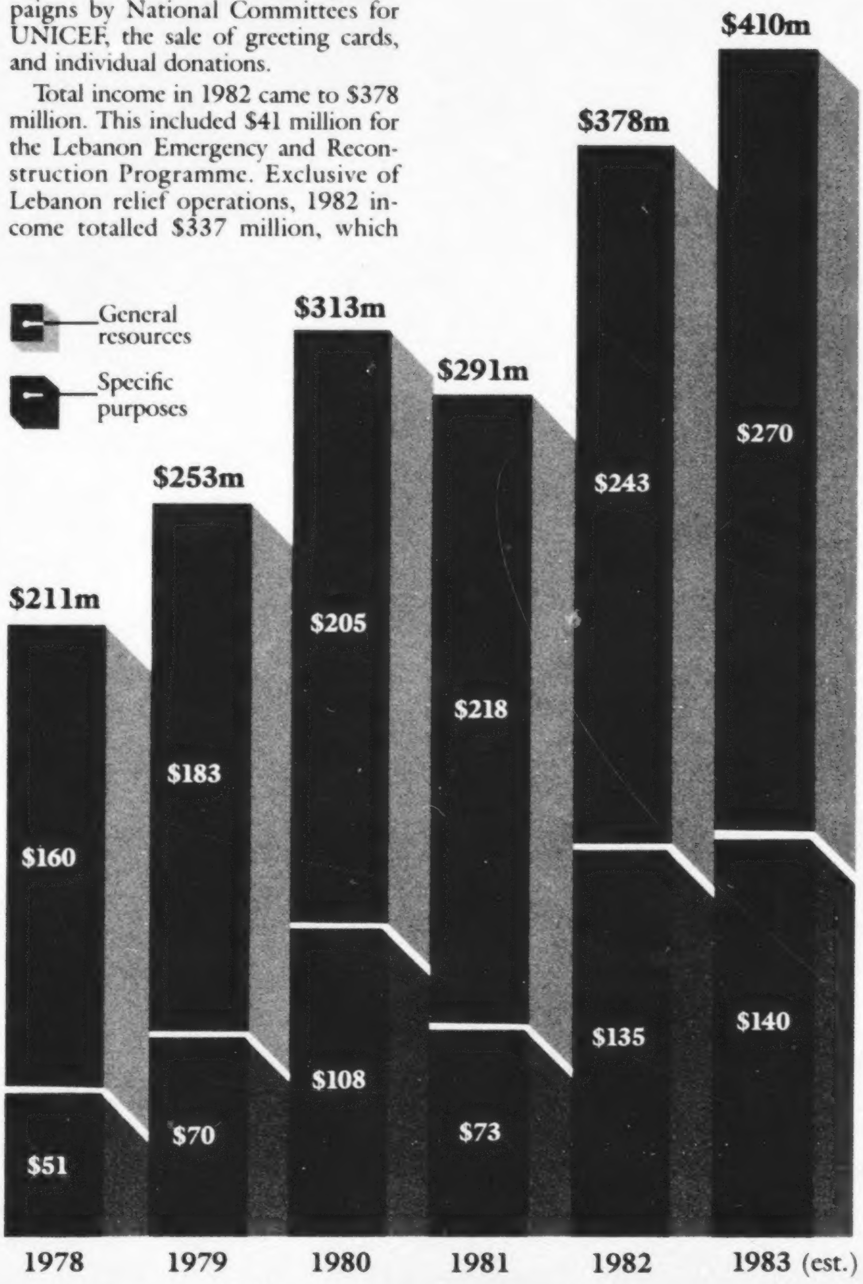
Emergency supplies from UNICEF's warehouse in Copenhagen are unloaded for distribution to mothers and children in war-torn Chad urgently in need of food and medical care.

UNICEF's finances: income, commitments, and expenditure 1982-83

Income

UNICEF's income comprises voluntary contributions from both governments and non-governmental sources. These latter include fund-raising campaigns by National Committees for UNICEF, the sale of greeting cards, and individual donations.

Total income in 1982 came to $378 million. This included $41 million for the Lebanon Emergency and Reconstruction Programme. Exclusive of Lebanon relief operations, 1982 income totalled $337 million, which represents a 26 per cent rise over the comparable income figure for 1981 ($268 million). This increase reflects the generous response by donors to a special appeal for additional resources towards the end of 1981. The income figures for 1982 would have been further augmented by nearly $30 million were it not for the effect of the strengthened U.S. dollar on the value of contributions in other currencies. A total income of $410 million is anticipated for 1983.



UNICEF Income 1978-83 (In millions of US dollars)

Income from governments and intergovernmental organizations accounted for 79 per cent of UNICEF's total income in 1982, with non-governmental income accounting for 21 per cent. The pie charts on page 40 show the division between governmental and non-governmental income for the years 1978 and 1982. The map on pages 38 to 39 shows individual government contributions by country for 1982; a list of non-governmental contributions by country appears on page 40.

Contributions

UNICEF's income is divided between contributions for general resources and contributions for specific purposes. General resources are the funds available to fulfill commitments for co-operation in country programmes approved by the Executive Board, and to meet administrative and programme support expenditures.

General resources include contributions from more than 130 governments, the net income from the Greeting Cards Operation, funds contributed by the public, and other income.

Contributions for specific purposes are those sought by UNICEF from governments and intergovernmental organizations as supplementary funds to support projects in the developing world for which general resources are insufficient, or for relief and rehabilitation programmes in emergency situations which by their nature are unpredictable. A policy paper on Supplementary Funding is being submitted to the 1983 Executive Board session. As illustrated in the bar chart on this page, about 30 per cent of UNICEF's total income over the period 1978-82 was contributed for specific purposes.

1982 governmental contributions (in thousands of US dollars)

Contributions to UNICEF's general resources are shown at right; additional contributions for specific purposes are shown in colour, at left.

The World on the Azimuthal Equidistant Projection centered at New York City.

ASIA

Afghanistan		30.0
Bangladesh	10.3	6.0
Bhutan		2.5

OCEANIA

Australia	8,071.7	3,672.6
Fiji		2.0
New Zealand		538.5
Solomon Islands		0.5

NORTH AMERICA

Canada	2,393.2	9,799.4
United States of America	13,100.0	41,500.0

LATIN AMERICA

Antigua		0.3
Argentina		90.2
Bahamas		3.0
Barbados		5.0

Burma		215.1
China	20.0	250.0
Hong Kong		16.7
India		1,945.4
Indonesia		670.1
Japan	980.8	8,219.8
Laos		5.0
Malaysia		98.4
Maldives		3.0
Mongolia		3.5
Nepal		8.0
Pakistan		130.2
Philippines		517.0
Republic of Korea		147.0
Singapore		1.4
Sri Lanka		12.6
Thailand	5.0	292.9
Viet Nam		4.4

EUROPE

Austria	1,183.5	839.3
B.S.S.R.		78.9
Belgium	506.3	673.4
Bulgaria		58.7
Czechoslovakia		81.0
Denmark	14,731.9	5,207.4
European Economic Community	3,858.0	
Finland	633.5	2,278.8
France		1,740.6
German Democratic Republic		117.2
Germany, Federal Republic of	1,310.0	4,936.2
Greece		130.0
Holy See		1.0
Hungary		21.4
Iceland		21.1
Ireland		316.5
Italy	13,627.3	17,475.7
Luxembourg		17.3
Malta		5.0
Monaco		3.5
Netherlands	9,625.0	8,423.8
Norway	4,357.9	14,642.8
Poland		78.9
Portugal		15.0
Romania		13.6
San Marino	4.6	
Spain		259.9
Sweden	9,258.9	20,958.0
Switzerland	3,291.0	3,791.2
Ukrainian S.S.R.		157.8
U.S.S.R.		852.0
United Kingdom	60.9	10,280.1
Yugoslavia		250.0

MIDDLE EAST

Arab Fund for Economic and Social Development (AFESD)	318.7	
AGFUND	21,000.0	
Bahrain		7.5
Democratic Yemen		5.8
Egypt		72.1
Iran		10.0
Iraq		121.6
Israel		50.0
Jordan		28.0
Kuwait	150.0	200.0
Lebanon	9,272.5	62.0
Oman	1,000.0	50.0
Qatar		200.0
Saudi Arabia	6,000.0	1,000.0
Syrian Arab Republic		25.6
Turkey		168.5
United Arab Emirates		799.5
Yemen		22.3

INTER-REGIONAL

The OPEC Fund	2,365.0	

AFRICA

Algeria		150.8
Benin		11.8
Botswana		9.0
Burundi		1.7
Central African Republic		25.6
Congo		14.6
Djibouti		2.0
Ethiopia		49.3
Gambia		5.0
Guinea		38.8
Ivory Coast		63.6
Kenya		24.0
Lesotho		2.1
Liberia		20.0
Libyan Arab Jamahiriya	1,000.0	
Madagascar		7.9
Malawi		3.7
Mauritius		3.8
Morocco		100.0
Mozambique		5.0
Nigeria	44.0	226.4
Rwanda		8.2
Senegal		30.3
Seychelles		1.0
Somalia		4.0
Sudan		35.0
Swaziland		5.8
Togo		8.7
Tunisia		60.4
Uganda		1.9
United Republic of Cameroon		76.2
United Republic of Tanzania		29.3
Zaire		13.0
Zambia		19.5
Zimbabwe		5.0

Bolivia		16.0
Brazil	22.2	100.0
British Virgin Islands		0.1
Chile	5.0	230.0
Colombia		431.6
Costa Rica		11.0
Cuba		139.7
Dominica		0.5
Ecuador		27.1
Grenada		1.0
Guatemala		37.3
Guyana		4.5
Honduras		20.0
Jamaica		9.5
Mexico	5.0	285.3
Panama		22.0
Saint Vincent and the Grenadines		0.7
St. Kitts-Nevis-Anguilla		0.7
Trinidad and Tobago		10.4
Venezuela		200.0

1982 non-governmental contributions (in US dollars)

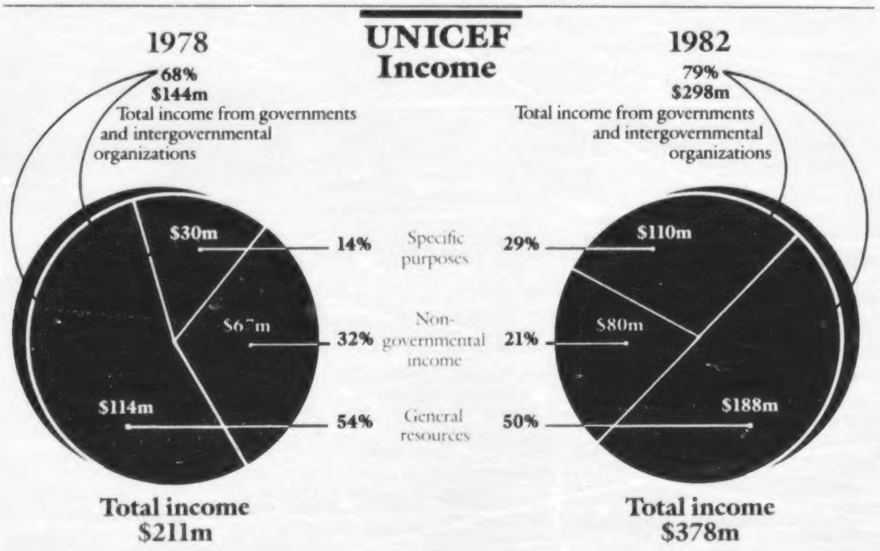
Countries where non-governmental contributions exceeded $10,000 (figures include proceeds from greeting card sales)

Algeria	134,688
Angola	55,021
Arab Gulf Fund	2,973,715
Argentina	186,365
Australia	1,020,597
Austria	692,345
Bahrain	12,209
Bangladesh	31,334
Belgium	1,186,293
Bolivia	23,798
Brazil	1,529,363
Bulgaria	460,712
Canada	7,101,343
Chile	355,946
Colombia	257,989
Cuba	30,323
Cyprus	15,068
Czechoslovakia	31,803
Denmark	631,832
Dominican Republic	26,519
Ecuador	43,580
Egypt	25,310
El Salvador	14,997
Ethiopia	18,342
Finland	2,153,590
France	9,614,640
German Democratic Republic	43,933
Germany, Federal Republic of	8,793,628
Ghana	130,867
Greece	239,842
Guatemala	19,709
Guyana	13,336
Honduras	10,055
Hungary	57,112
Iceland	14,508
India	573,948
Indonesia	33,161
Iraq	21,499
Ireland	164,829
Italy	999,997
Ivory Coast	22,655
Japan	5,557,366
Kenya	24,951
Lebanon	25,193
Luxembourg	107,409
Malaysia	26,865
Mexico	93,558
Monaco	10,963
Morocco	29,353
Mozambique	29,814
Netherlands	2,803,174
New Zealand	151,663
Nicaragua	15,068
Nigeria	153,377
Norway	925,289
Pakistan	42,086
Panama	19,840
Paraguay	31,588
Peru	135,686
Philippines	51,478
Poland	295,428
Portugal	36,567
Romania	37,996
Saudi Arabia	25,634
Senegal	26,259
Singapore	20,763
Spain	2,243,097
Sri Lanka	20,606
Sweden	845,347
Switzerland	4,185,024
Thailand	50,105
Trinidad & Tobago	19,174
Tunisia	12,257
Turkey	113,977
Uganda	94,772

Projects funded by specific purpose contributions are normally prepared in the same way as those funded from general resources. Most are in countries classified by the United Nations as "least developed" or "most seriously affected".

Pledging Conference

As a result of pledges at the United Nations Pledging Conference for Development Activities in November 1982, and further pledges made subsequently, UNICEF's income for general resources in 1983 is expected to total $270 million. Some of the larger increases pledged so far, in percentage terms based on national currency, are: Australia 10%; Finland 100%; France 54%; Italy 14%; Japan 24%; and Norway 22%. Certain governments have yet to pledge.



Expenditures

The Executive Director authorizes expenditures to fulfill commitments approved by the Board for programme assistance and for the budget. The pace of expenditure on a country programme depends on the speed of implementation in the country concerned.

In 1982, UNICEF's total expenditure for programmes came to $213 million, including $75 million in cash assistance, in training costs and other local expenses, and $138 million in supply assistance. The cost of administrative services, and programme support at field level, was $76 million.

United Arab Emirates	81,022
United Kingdom of Great Britain and Northern Ireland	893,190
United Republic of Tanzania	59,382
United States of America	18,507,529
Uruguay	166,145
Venezuela	81,375
Yemen	15,944
Yugoslavia	385,280
Zambia	36,023
Contributions under $10,000	172,749
TOTAL..............	**78,427,167**
Less costs of Greeting Card Operations*	(16,261,320)
Net available for UNICEF assistance	62,165,847

*Costs of producing cards, brochures, freight, overhead.

The bar chart on this page shows expenditures on programme assistance for 1978 to 1982 and projected expenditures for 1983. The bar and pie charts on the next page show programme expenditures by sector from 1978 to 1982, by amount and by proportion respectively.

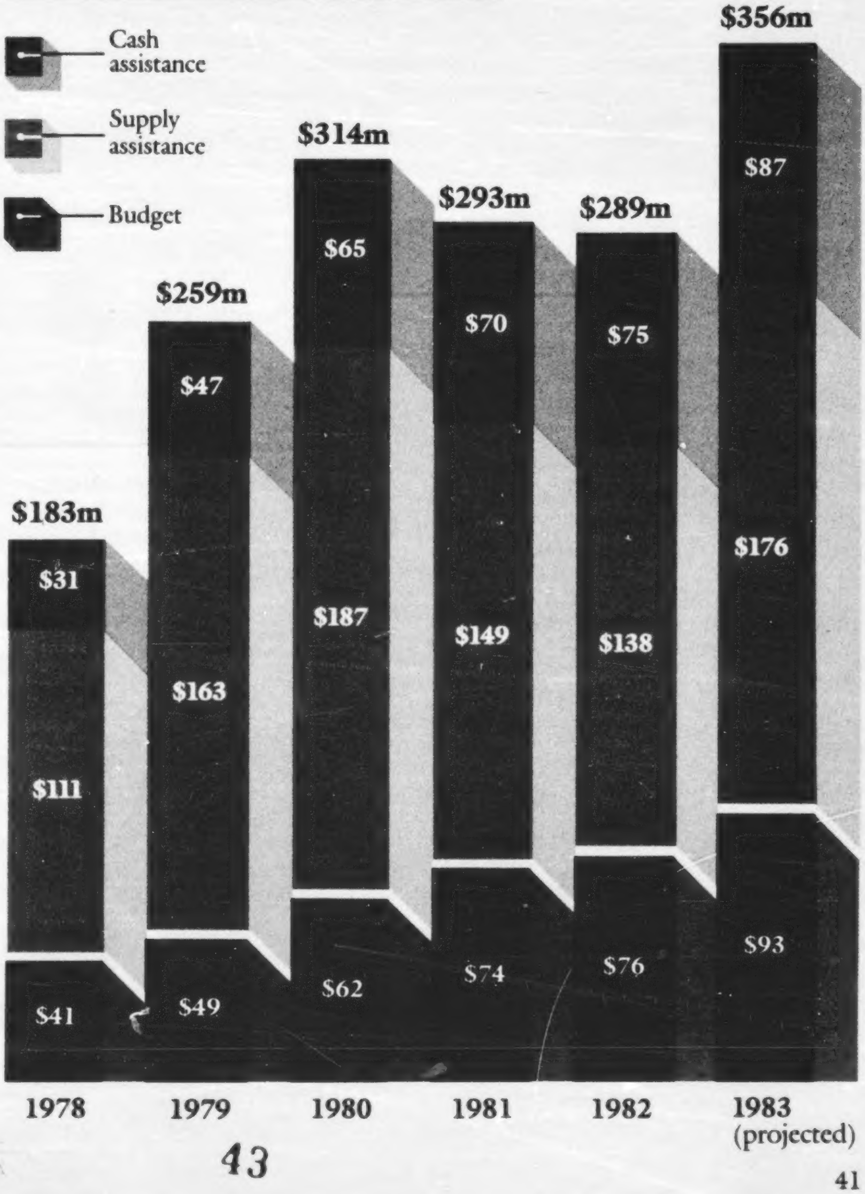
Financial plan and prospects

The difficult global economic situation, whose worst effects are felt among women and children in the developing world, has at the same time reduced the flows of development assistance available to help them. There has been a dampening effect on UNICEF's own income expectations. Meanwhile UNICEF is striving to maintain the value in real terms of its level of resources at a time when the economic and political trend is not flowing in favour of multilateral agencies generally. UNICEF is therefore endeavouring to persuade donor governments not to trim their social development assistance; and to maintain, or increase, the level of their contributions to UNICEF in real terms so as to help offset the negative effect on overall income of the strengthened US dollar. UNICEF is also encouraging the non-governmental sector, through the National Committees and other NGOs, to expand their important contributions.

At the May 1983 session of the Executive Board, proposals for new or extended multi-year programme commitments in 52 countries will be submitted. (UNICEF currently co-operates in programmes in 112 countries.) The proposed new commitments total $109 million from UNICEF's general resources and $136 million for projects deemed worthy of support if supplementary funds are forthcoming. Programme commitments from general resources for all the countries where UNICEF co-operates are shown on the map on pages 24-25.

A Medium Term Plan covering the years 1982-86 will be submitted to the Executive Board at its May 1983 session. The plan anticipates a 1983 income level of $410 million, which represents an increase of 8 per cent over 1982. Similarly modest increases

UNICEF Expenditures (In millions of US dollars)



are foreseen through 1986 in view of the decidedly mixed prospects for the world economy. The downturn in expectations for overall financial growth has implications which are reflected in the biennial budget proposed for 1984/85.

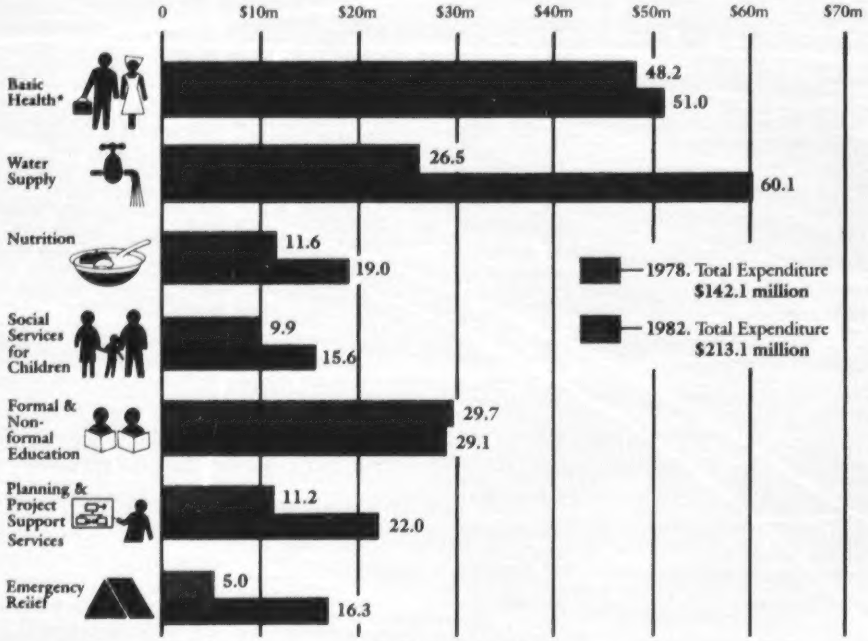
The biennial budget 1984/85

UNICEF is committed to finding cost-effective solutions to programme planning and delivery. Similarly, the organization is committed to finding the most effective and efficient means of deploying internal UNICEF resources through consolidation, redeployment, investment and decentralization. Accordingly, preparations for the proposed 1984/85 budget have followed the provisions set out in the Medium Term Plan approved at the May 1982 Board session that there should be no growth in professional staffing levels; and that the rate of growth in budget, or "overhead", costs should not exceed that of planned expenditure on programmes. The 1984/85 budget for administrative and programme support services at headquarters in New York and Geneva, as well as in Copenhagen, Sydney and Tokyo, and in UNICEF's 87 field offices around the world, which the Executive Board will be asked to approve at its May 1983 session, amounts to $218 million.

Within the framework of "no growth" in professional staffing levels, which has been applied most stringently to the operations at the headquarters duty stations, there is one major opportunity for efficiency savings and manoeuvrability: the consolidation of the UNICEF supply function in the Integrated Supply Centre in Copenhagen. This will be completed within the next 12-18 months, and the resulting "savings" in professional posts have allowed UNICEF to re-examine its staffing pattern. A number of posts will be redeployed in the field, particularly in those parts of the world which for historical reasons are comparatively under-staffed.

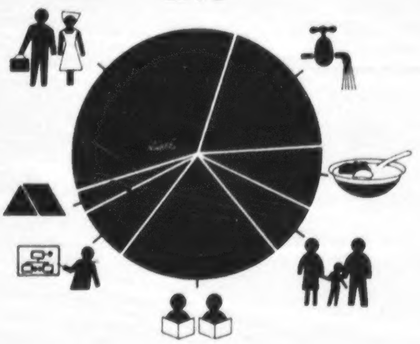
It is in Africa that this situation is most evident, and particularly in the West African region. The decision to reallocate posts to certain duty stations in this region, and to a lesser extent in Eastern Africa, also stems from donor governments' perception that this is the area of the developing world where women and children are most in need of increased assistance; and from the Executive Board's recommendation at its May 1982 session that UNICEF become more operational at intermediate and local levels of programming. This policy decision with regard to financial, staffing, and administrative reallocations also reflects a conscious effort to shift resources towards those countries with higher infant mortality rates.

Expenditure on Programmes by Sector

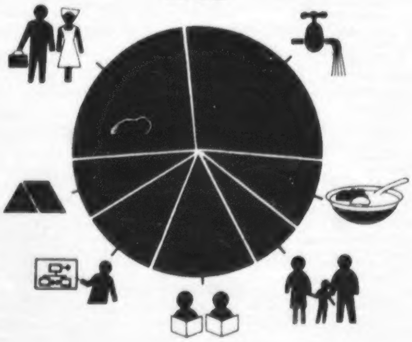


*Family planning component is included in basic health.

1978



1982



Liquidity Provision

UNICEF works with countries to prepare programmes so that commitments can be approved by the Executive Board in advance of major expenditures on these programmes. UNICEF does not hold resources to cover the cost of these commitments, but depends on future income to cover expenditures from general resources. The organization does, however, maintain a liquidity provision to cover temporary imbalances between income received and spent, as well as to absorb differences between income and expenditure estimates.

What UNICEF is and does

Origins and current mandate

The United Nations International Children's Emergency Fund was created on 11 December 1946 by the General Assembly of the United Nations during its first session. In its first years, the Fund's resources were largely devoted to meeting the emergency needs of children in post-war Europe and China for food, drugs and clothing. In December 1950, the General Assembly changed the Fund's mandate to emphasize programmes of long-range benefit to children of developing countries. In October 1953, the General Assembly decided that UNICEF should continue this work indefinitely and its name was changed to United Nations Children's Fund, although the well-known acronym "UNICEF" was retained.

In 1976, the General Assembly proclaimed 1979 as the International Year of the Child (IYC) and designated UNICEF as the lead agency of the United Nations system responsible for co-ordinating support for the Year's activities, mainly undertaken at national level. In 1979, at the end of the Year, the General Assembly designated UNICEF the lead agency of the United Nations system for IYC follow-up. UNICEF thus took on a responsibility for drawing attention to needs and problems common to children in both developing and industrialized countries. Although this extended UNICEF's area of concern, it did not diminish the Fund's overriding preoccupation with the problems of children in developing countries.

Combining humanitarian and development objectives, UNICEF co-operates with developing countries in their efforts to protect their children and to enable them to fulfill their potential. This co-operation takes place within the context of national development efforts. Its ultimate goal is to enable every child to enjoy the basic rights set out in the International Declaration of the Rights of the Child, and to contribute to their country's progress and well-being. At the same time, UNICEF in no way emphasizes investment in children exclusively in terms of social utility. Recognition is given to the intrinsic value of childhood, and to nurturing the imagination and spirit of children.

UNICEF is unique among the organizations of the United Nations system in having a concern for a particular age-group rather than a particular field such as health or education. A large measure of public support is essential for the realization of UNICEF's objectives because of the

ICEF 9044/Wolff

UNICEF's overriding concern is the problems of children in the developing countries. UNICEF reaches children through their mothers, their families, and their communities.

high level of national and international priority UNICEF tries to secure on behalf of children. For this reason, UNICEF places great importance in its relationships with the National Committees for UNICEF and with non-governmental organizations.

Organization

UNICEF is an integral part of the United Nations but it has a semi-autonomous status, with its own governing body, the Executive Board, and its own secretariat. The Board establishes UNICEF's policies, reviews programmes and commits funds for projects and the work of the organization. To assist in its work the Board has a Programme Committee and a Committee on Administration and Finance. The Board has a regular main annual session and its reports are reviewed by the Economic and Social Council and the General Assembly.

From 1957 to 1982 the Board had a 30-nation membership, 10 members being elected each year for a three-year term by the UN Economic and Social Council. Following agreement reached at a special Board session in April 1982, membership was enlarged to 41 countries, which continues to be elected by rotation for three-year terms. The membership is constituted as follows: nine members from Africa, nine from Asia, six from Latin America, 12 from Western Europe and other areas, and four from Eastern Europe. The 41st seat rotates among these regional groups.

The Executive Director, who is responsible for the administration of UNICEF, is appointed by the United Nations Secretary-General in consultation with the Board. Since January 1980, the Executive Director has been Mr. James P. Grant.

UNICEF field offices are the key operational units for advocacy, advice, programming and logistics. Under the overall responsibility of the UNICEF Representative, programme officers assist relevant ministries and institutions with the preparation and implementation of programmes in which UNICEF is co-operating. In 1982 UNICEF maintained 87 field offices serving 112 countries, with 609 professional and 1,253 clerical and other general service posts.

In 1982, 199 professional and 322 general staff were maintained in New York and Geneva, for service of the Executive Board, policy development and direction, supplies, procurement, financial and personnel management, audit, information, and relations with donor governments, National Committees for UNICEF, and non-governmental organizations. In addition, UNICEF maintains a packing and assembly centre for supplies and shipment in Copenhagen, which is shortly to become the administrative headquarters of UNICEF's newly streamlined and consolidated supplies operations. These staff and services are now provided under a unified biennial budget, which in 1982-83 replaced the previous yearly programme support budget and administrative services budget.

UNICEF co-operation with developing countries

UNICEF co-operates in programmes in a country only in consultation with the government. The actual administration of a programme is undertaken by the government, and is the responsibility of the government, or of organizations designated by it.

The problems of children require a flexible, country-by-country approach. No one formula applies equally in countries at different levels of development, with cultural, geographical and economical diversities, and widely varying administrative structures. UNICEF seeks to adjust the pattern of its co-operation to correspond to national and sub-national variations.

UNICEF co-operates with developing countries in several ways. It assists in the planning and extension of services benefiting children, and in the exchange of experience between countries. It provides funds to strengthen the training and orientation of national personnel, and it delivers technical supplies, equipment and other aid for extending services.

Co-operation is extended to programmes through a number of sectoral ministries, such as health, education, social services, agriculture and those ministries or other authorities responsible for rural development, community development, and water supply and sanitation.

The major fields of UNICEF co-operation are child health, including

ICEF 8295/Wolff

Mothers in a slum in Cairo prepare a meal for their infants from breastmilk substitutes. Wrong dilution and poor hygiene often cause infection.

the extension of maternal and child health services, mainly at the local level, in the framework of primary health care; water supply for drinking and household use, and environmental sanitation; child nutrition; primary and non-formal education; social welfare services for children; the improvement of the situation of women; and emergency relief and rehabilitation.

However, in communities these problems are usually not perceived or experienced by sector, and technical support is often needed from several ministries. The problem of child malnutrition, for example, is usually a combined problem of poverty, inadequate health services, and food shortages; it may also stem from lack of birth spacing and clean water and sanitation, or from dietary ignorance. Efforts in any one sector may fail if corresponding efforts in others are not made simultaneously. UNICEF therefore recommends a multisectoral approach encompassing both the technical and the social elements of programmes.

Basic services

Community participation is the key element of the "basic services strategy" advocated by UNICEF. This strategy, evolved through experience in many countries with differing economic and political systems, is an alternative to that of relying on the slow spread of conventional health, education and social services to meet the urgent needs of children and mothers.

The approach perceives social and economic improvement in low-income rural and urban communities as heavily dependent on the involvement and participation of the communities themselves. The role of government, non-government organizations and external co-operation is, first, to stimulate assessment by the community of its children's needs and its agreement to participate in meeting some of them; second, to strengthen the technical and administrative infrastructure through which family and community efforts can be supported; third to provide through this infrastructure financial and technical inputs, as well as supplies and training opportunities which match the community's capacity to absorb them.

A young Bangladeshi girl collects water from a village pump. A clean water supply, so essential to healthy living, is seen as one of the key links in the basic services chain.

ICEF 9112/Thomas

An essential feature of the approach is the selection by the community of one or more of its members to serve as community workers after brief practical training, repeated and extended through refresher courses. These workers are then on hand to deal with community needs and can refer problems beyond their competence or resources to the relevant services at the next level of the system. To support the community workers, the peripheral and intermediate-level government services often have to be strengthened, particularly with paraprofessionals.

Given enough support from outside the community, a great deal can be done within it to improve services which affect the well-being of children. By mobilizing hitherto unused competence within the community, this can be done at recurrent costs which the country and the community can afford.

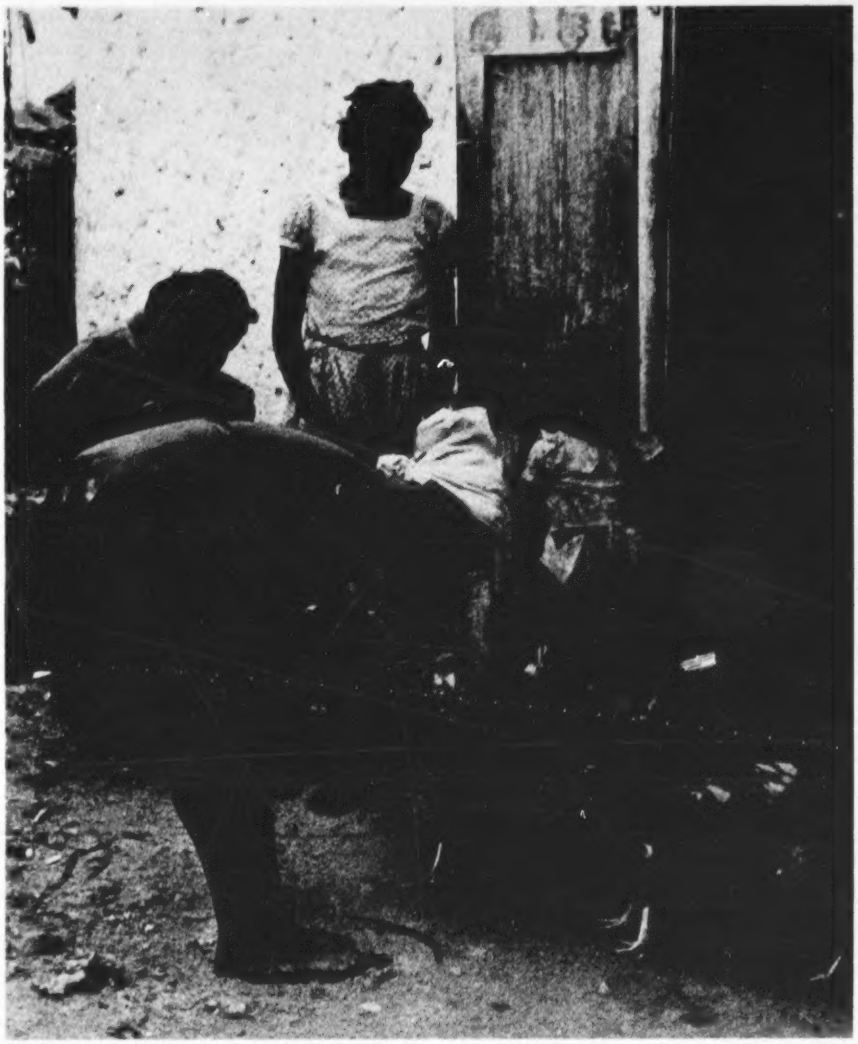
Criteria for co-operation

UNICEF is primarily concerned with the long-term priority problems of children. It tries to encourage governments to undertake a regular review of the situation of their children and to include a national policy for children in their comprehensive development plans.

UNICEF's criteria in working with governments on development of national services include the following:

- as a fundamental objective, the strengthening the country's capacity to deal progressively with the needs and problems of its children;
- priority to strengthening services benefiting children in low-income or other deprived groups, aiming eventually at universal rural and urban coverage;
- support for innovative and "pre-investment" projects in order to test methods that may subsequently be used on a larger scale;
- emphasis on the use of national or regional expertise;
- the strengthening and extension of in-country efforts to train and provide orientation for personnel involved in services benefiting children;
- evaluating continuing costs to the country as carefully as those to UNICEF;
- viewing the cost of UNICEF co-operation benefits to children (direct or indirect), irrespective of any additional benefits to other age groups;
- giving relatively more support to programmes benefiting children in the least developed and other low-income countries.

UNICEF places great store in its relationships with other like-minded agencies. In the Haitian countryside, an NGO nutrition project has provided loans to buy poultry.



ICEF 9321/Black

Relations within the United Nations System

UNICEF is part of a system of co-operative relationships among the various organizations of the United Nations system. It also works with bilateral aid agencies and non-governmental organizations, recognizing that the impact of programmes intended to benefit children can be substantially increased when a combination of financial resources, and of technical and operating skills, is applied to their design and implementation. This system of relationships helps UNICEF avoid spreading its co-operation too thinly among different sectoral concerns in developing countries. In certain countries, UNICEF's contribution towards dealing with a particular problem may be small in money terms, but catalytic in effect, providing a nucleus of preparation for larger-scale co-operation whereby an approach may be tested and proven before substantial investments are made by other organizations with far greater resources.

Within the United Nations system, collaboration ranges from the sharing of expertise at the country level in developing programmes which require an interdisciplinary approach, to systematic exchanges between organizations on policies and relevant experience. These exchanges occur both through the machinery of the Administrative Committee on Co-ordination (ACC), and through periodic inter-secretariat meetings held with other United Nations organizations such as the World Bank, the United Nations Development Programme (UNDP), the Food and Agriculture Organization (FAO) and the United Nations Educational, Scientific and Cultural Organization (UNESCO). Agencies also discuss common concerns through the Consultative Committee on Policies and Programmes for Children, the successor to the interagency advisory group established during the International Year of the Child (IYC), 1979.

UNICEF's policies for co-operation in country programmes benefit from the technical advice of specialized agencies of the United Nations such as the World Health Organization (WHO), FAO, UNESCO, and the International Labour Organization (ILO). At the country level, UNICEF does not duplicate services available from the specialized agencies, but works with them to support programmes, particularly where ministries such as health and education are involved, with which the relevant specialized agency has relations. In addition, the specialized agencies from time to time collaborate with UNICEF in preparing joint reports on particular programme areas. In particular there is a Joint UNICEF/WHO Committee on Health Policy (JCHP) which advises on policies of co-operation in health programmes and undertakes periodic reviews.

UNICEF representatives in the field work with the UNDP Resident Representatives, most of whom are designated by the Secretary-General as Resident Co-ordinators for operational activities. Although UNICEF is not an executing agency of UNDP, it exchanges information with all the agencies involved in UNDP country programme exercises.

UNICEF co-operates in country programmes together with other funding agencies of the United Nations system, such as the World Bank, the United Nations Fund for Population Activities (UNFPA), and the World Food Programme (WFP). It also works with regional development banks and regional economic and social commissions on policies and programmes benefiting children. Increasingly, UNICEF has sought collaboration with bilateral agencies at field level to channel more of their resources into programmes which UNICEF cannot fund by itself.

In the case of emergencies, UNICEF works with the Office of the United Nations Disaster Relief Co-ordinator (UNDRO), the United Nations High Commissioner for Refugees (UNHCR), and other agencies of the United Nations system such as the World Food Programme, the League of Red Cross Societies and the International Committee of the Red Cross.

Relations with non-governmental organizations

UNICEF has always worked closely with the voluntary sector. Over the year UNICEF has developed close working relationships with international non-governmental organizations (NGOs) whose work bears on the situation of children. Many of these organizations (professional, development assistance, service, religious, business, trade and labour organizations) have become important supporters of UNICEF, both by providing a channel for advocacy on behalf of children, and by their participation in fund-raising and in programmes.

National and local non-governmental organizations are also playing an increasingly important role in UNICEF's programme co-operation in developing countries in the light of UNICEF's emphasis on community participation in basic services. Many NGOs have a flexibility and a freedom to respond to neglected problems, or have a presence in remote and deprived areas where little or no other service infrastructure yet exists. Such NGOs can act as vital links between the community and government authorities and unlike UNICEF can work directly with local communities to help them mobilize their own resources and plan basic services. In certain situations, NGOs are designated by governments to carry out part of the programmes with which UNICEF is co-operating. Through innovative projects, NGOs can experiment with models for development co-operation which UNICEF and others can subsequently adapt in other areas or undertake on a wider scale.

Non-governmental organizations also provide UNICEF with information, opinion and recommendations in fields where they have special competence, and in some cases undertake studies on behalf of, or in co-operation with, UNICEF. Following one such special study on childhood disability undertaken by Rehabilitation International, an ongoing partnership has been developed between the two organizations to reinforce mutual efforts.

As a result of the International Year of the Child (IYC), many non-governmental organizations expanded their activities, fund-raising and advocacy efforts, on behalf of children. Among them were some organizations not traditionally concerned with children. UNICEF is continuing to foster these relationships providing information, and encouraging joint programmes on issues affecting children in developing and industrialized countries, between NGOs, governments and UNICEF.

ICEF 8823/Azhar

Local institutions are becoming closer partners in UNICEF co-operation in the light of emphasis on community participation. A midwife from a local hospital in an Islamabad slum.

National Committees for UNICEF

The National Committees for UNICEF, normally organized in industrialized countries, play an important role in helping to generate a better understanding of the needs of children in developing countries and of the work of UNICEF. The Committees of which there are now 33, are concerned with increasing financial support for UNICEF, either indirectly through advocacy, education and information, or directly through the sale of greeting cards and other fund-raising activities.

In 1982, UNICEF received $41 million collected under the auspices of the National Committees. Also, in 1982, $13.6 million in net income was received from the Greeting Card Operation for which the Committees were the main sales agents. The increasing activism of National Committees has brought notable results, particularly in fund-raising, promotional and informational activities, and development education. A number of committees have been instrumental in drawing wide public attention to emergency situations affecting children as well as to the "silent emergencies" confronting the children of the developing countries year-in, year-out. In recent years, there has been a closer relationship between National Committees and UNICEF's field operations, with committee members from a number of countries undertaking collective study tours to the field to enhance their knowledge of the needs of children in the developing countries. An important function of the committees is advocacy with their own governments for increased assistance to meet these needs.

Greeting Cards

UNICEF's world famous greeting cards, calendars and stationery items are a significant source of income for the organization's activities on behalf of children. Reproduction rights of the designs are contributed without payment by renowned artists and leading museums throughout the world. The collaboration of thousands of volunteers, working under the auspices of National Committees for UNICEF or other NGOs, plays a vital role in the success of the annual sales campaigns around the world—campaigns which provide both the volunteers and the general public with an opportunity to support personally the work of UNICEF.

This worldwide volunteer network has expanded yearly within the private and public sectors as well, to include schools, banks, post offices, supermarket chains, shopping malls, stationery and department stores, museums, major corporations, and a diverse range of small businesses.

Following the recommendation of the UNICEF Executive Board, in 1982 more than one million cards were printed in three developing countries: India, Pakistan and Nepal. In 1983, the Greeting Cards Operation will market 500,000 Nepalese handcrafted cards purchased from a UNICEF-supported community development project, which is targeted to improve income and basic services for about 2,000 families.

During the season ending 30 April 1982, over 115 million cards, 496,000 calendars, and 290,000 stationery-related items were sold in 145 countries. Net income to UNICEF was $16.7 million.

Funding

In 1982 UNICEF received a total of $378 million.

All of UNICEF's income comes from voluntary contributions—from governments, from organizations, and from individuals. Most contributions are for UNICEF's general resources; or they may be for supplementary projects "noted" by the Board for support as resources become available, or for emergency relief and rehabilitation operations.

Although most resources come from governments, UNICEF is not a "membership" organization with an "assessed" budget; it cannot charge governments a share of its expenses. In 1982, 134 governments of both industrialized and developing countries voluntarily contributed to UNICEF, providing about 79 per cent of its total income.

Individuals and organizations are also essential sources of UNICEF's income, accounting for about 21 per cent in 1982. As what is often described as the "people to people" arm of the United Nations, UNICEF enjoys a unique relationship with private organizations and the general public throughout the world. Public support is manifested not only through greeting card sales, but through individual contributions, the proceeds from benefit events ranging from concerts to football matches, grants from organizations and institutions, and collections by school children. Often these fund-raising efforts are sponsored by National Committees for UNICEF.

Despite the modest volume of its financial resources, UNICEF is one of the largest sources of co-operation in national services and programmes benefiting children. Fund-raising for UNICEF is part of a larger objective of encouraging the greater deployment of resources for services benefiting children.

UNICEF's fund-raising strategy aims at meeting the financial projections in its medium-term work plan by actively working to increase contributions from its traditional major donors while developing support from other potential sources.

Information on the funds contributed by the recently created Arab Gulf Programme for United Nations Development Organizations (AGFUND) during 1981 and 1982 appears in the main Review chapter of this report. The moving force behind AGFUND is its president, UNICEF's Special Envoy, H.R.H. Prince Talal Bin Abdul Aziz Al Saud of Saudi Arabia. □

The following documents were prepared for the May 1983 Executive Board session:

An overview of UNICEF policies, organization and working methods—C,E,F,R,S,* (E/ICEF/670/Rev. 2)

Report of the Executive Director, 1983—C,E,F,R,S,* (E/ICEF/698), including: Introduction; Accelerating action on child health and nutrition; Other programme highlights for 1982; Programme support activities; Emergency relief and rehabilitation; International and community support; and Financial matters.

UNICEF budget estimates for the biennium 1984-1985—C,E,F,R,S,* (E/ICEF/AB/L.249)

Medium-term plan for the period 1982-1986—C,E,F,R,S,* (E/ICEF/699)

Financial report and statements for the year ended 31 December 1982—C,E,F,R,S,* (E/ICEF/AB/L.247)

Summary of recommended 1983 programme commitments and 'notings'—C,E,F,R,S,* (E/ICEF/P/L.2149)

Supply Division consolidation: estimate of non-recurring costs—C,E,F,R,S,* (E/ICEF/AB/L.244)

Report of the February 1983 meeting of the WHO/UNICEF Joint Committee on Health Policy—C,E,F,R,S,* (E/ICEF/L.1456)

Lebanon emergency relief operations—C,E,F,R,S,* (E/ICEF/Misc.400)

Alternative programme approaches in different socio-economic situations—C,E,F,R,S,* (E/ICEF/L.1453)

Supplementary funding and specific-purpose contributions in UNICEF—C,E,F,R,S,* (E/ICEF/L.1454)

UNICEF's external relations—C,E,F,R,S,* (E/ICEF/L.1455)

The full list of pre-session documentation is contained in a provisional checklist of UNICEF documents (E/ICEF/1983/CRP.2), which includes the reports from UNICEF's regional offices (E/ICEF/L.1458 to 1463)

The following publications issued by UNICEF provide background and additional information about the needs of children and the work of UNICEF:

Les Carnets de l'Enfance/Assignment Children, a bi-annual review—E,F,*

UNICEF News, published quarterly, containing articles on UNICEF-related programmes and activities—E,F,G,S,*

Facts about UNICEF, 1982-1983 (leaflet)—E,F,S,*

Ideas Forum, a newspaper with ideas and actions for the NGO constituency—E,F,*

State of the World's Children report and press kit, published annually by UNICEF—A,E,F,P,S,*

UNICEF Films, a catalogue of films that UNICEF has produced or co-produced—E,F,S,*

UNICEF catalogue of information materials, revised annually E,F,S,*

*Documents and publications are available from the UNICEF offices listed overleaf in the languages indicated: A/Arabic, C/Chinese, E/English, F/French, G/German, P/Portugese, R/Russian, S/Spanish.

Further information about UNICEF and its work may be obtained from:

UNICEF Headquarters
United Nations, New York 10017

UNICEF Office for Europe
Information Division
Palais des Nations, CH 1211, Geneva 10,
Switzerland

UNICEF Office for North Africa
B.P. 660, Alger-Gare, Algeria

UNICEF Regional Office for East Africa
P.O. Box 44145, Nairobi, Kenya

UNICEF Regional Office for West Africa
04—P.O. Box 443, Abidjan 04
Ivory Coast

UNICEF Regional Office for the Americas
Calle 78 No. 11-43, Bogota, Colombia

UNICEF Regional Office for East Asia
and Pakistan
P.O. Box 2-154, Bangkok, Thailand

UNICEF Regional Office for the Eastern
Mediterranean
P.O. Box 5902, Beirut, Lebanon

UNICEF Regional Office for South Central
Asia
73 Lodi Estate, New Delhi 110003, India

UNICEF Office for Australia and
New Zealand
P.O. Box 4045, G.P.O., Sydney, Australia

UNICEF Office for Tokyo
c/o United Nations
Information Centre, 22nd floor
Shin Aoyama Building Nishikan
1-1, Minami—Aoyama 1-Chome
Minatū-Ku Tokyo 107
Japan

Information may also be obtained from the following Committees for UNICEF:

UNICEF Committee of Australia
156 Castlereagh Street
AUS-Sydney N.S.W. 2000

Austrian Committee for UNICEF
Vienna International Centre
(UNO-City)
22 Wagramer Strasse 9
A-1400 Vienna

Belgian Committee for UNICEF
1, rue Joseph II-Boite 9
B—1040 Brussels

Bulgarian National Committee
for UNICEF
c/o Ministry of Public Health
5, Lenin Place
BG—Sofia

Canadian UNICEF Committee
443, Mount Pleasant Road
CDN—Toronto, Ontario M4S 2L8

Czechoslovakia: Czechoslovak Committee
for Cooperation with UNICEF
Directeur de l'Institut de la médecine
expérimentale CSAV
U nemocnice 2
CS-128 08 Prague 2

Denmark: Danish Committee for UNICEF
Billedvej, 8
Frihavnen
DK—2100 Copenhagen

Federal Republic of Germany:
German Committee for UNICEF
Steinfelder Gasse 9
D—5000 Cologne 1

Finland: Finnish Committee for UNICEF
Pieni Roobertinkatu 11
SF—00130 Helsinki 13

France: French Committee for UNICEF
35, rue Félicien-David
F—75781 Paris Cedex 16

German Democratic Republic:
National Committee for UNICEF
of the German Democratic Republic
Warschauer Strasse 5
DDR—1034 Berlin

Greece: Hellenic National Committee
for UNICEF
Xenias Street 1
GR—Athens 611

Hungary: Hungarian National
Committee for UNICEF
Belgrád Rakpart, 24
H—1056 Budapest

Ireland: Irish National Committee
for UNICEF
4, St. Andrew Street
IRL-Dublin 2

Israel: Israel National Committee
for UNICEF
P.O. Box 3489
IL—Jerusalem

Italy: Italian Committee for UNICEF
Piazza Marconj 25
00144 Rome

Japan: Japan Association for UNICEF, Inc.
1-2, Azabudai 3-Chome. Minatū-Ku
J—Tokyo

Luxembourg: Luxembourg Committee
for UNICEF
99, Route d'Arlon
L–1140 Luxembourg

Netherlands: Netherlands Committee
for UNICEF
Bankastraat, 128
Postbus 85857
NL—2508 CN's-Gravenhage

New Zealand: New Zealand National
Committee for UNICEF, Inc.
5-7, Willeston Street, G.P.O. Box 122
NZ—Wellington 1

Norway: Norwegian Committee for UNICEF
Olaf Ryes Plass 8
N—Oslo 5

Poland: Polish Committee of Co-operation
with UNICEF
ul. Mokotowska, 39
PL—00651 Warsaw

Portugal: Portuguese Committee for UNICEF
Rua S. Boaventura 5
Colegio dos Inglezinhos
P–1200 Lisbon

Romania: Romanian National Committee
for UNICEF
6-8, Strada Onesti
R—7000 Bucharest 1

San Marino: National Commission for
UNICEF of San Marino
c/o Segreteria di Stato per gli Affari Esteri
SM—47031 San Marino

Spain: Spanish Committee for UNICEF
Mauricio Legendre, 36
Apartado 12021
E—Madrid 16

Sweden: Swedish Committee for UNICEF
Skolgränd, 2
Box 151 15
S—104 65 Stockholm

Switzerland: Swiss Committee for UNICEF
Werdstrasse 36
CH—8021 Zürich 1

Tunisia: Tunisian Committee for UNICEF
Le Colysée
Escalier B—Bureau 150
TN—Tunis

Turkey: Turkish National Committee for UNICEF
Abdullah Cevdet Sok. 22/10
TR–Cankaya

United Kingdom: United Kingdom
Committee for UNICEF
55 Lincolns Inn Fields
GB—London WC2A 3NB

United States of America: United States
Committee for UNICEF
331 East 38th Street
USA—New York, N.Y. 10016

Yugoslavia: Yugoslav National Committee
for UNICEF
Bulevar Lenjina 2
Palata Federaciji-Zapadno Krilo
YU–11070 Novi Beograd

Liaison Offices

Argentina: Argentine Association for UNICEF
Av. Belgrano 254
AR–1092 Buenos Aires

Cyprus: United Nations Association of Cyprus,
Sub-Committee for UNICEF
P.O. Box 1508
CY—Nicosia

Iceland: UNICEF in Iceland
Storagerdi, 30
IS—108 Reykjavik

U.S.S.R.: Alliance of Red Cross and Red
Crescent Societies/sojuz
Obshchestv Krasnogo Kresta i
Krasnogo Polumesiatsa 1,
Cheremushkinskii Proezd, 5
SU—Moscow 117036